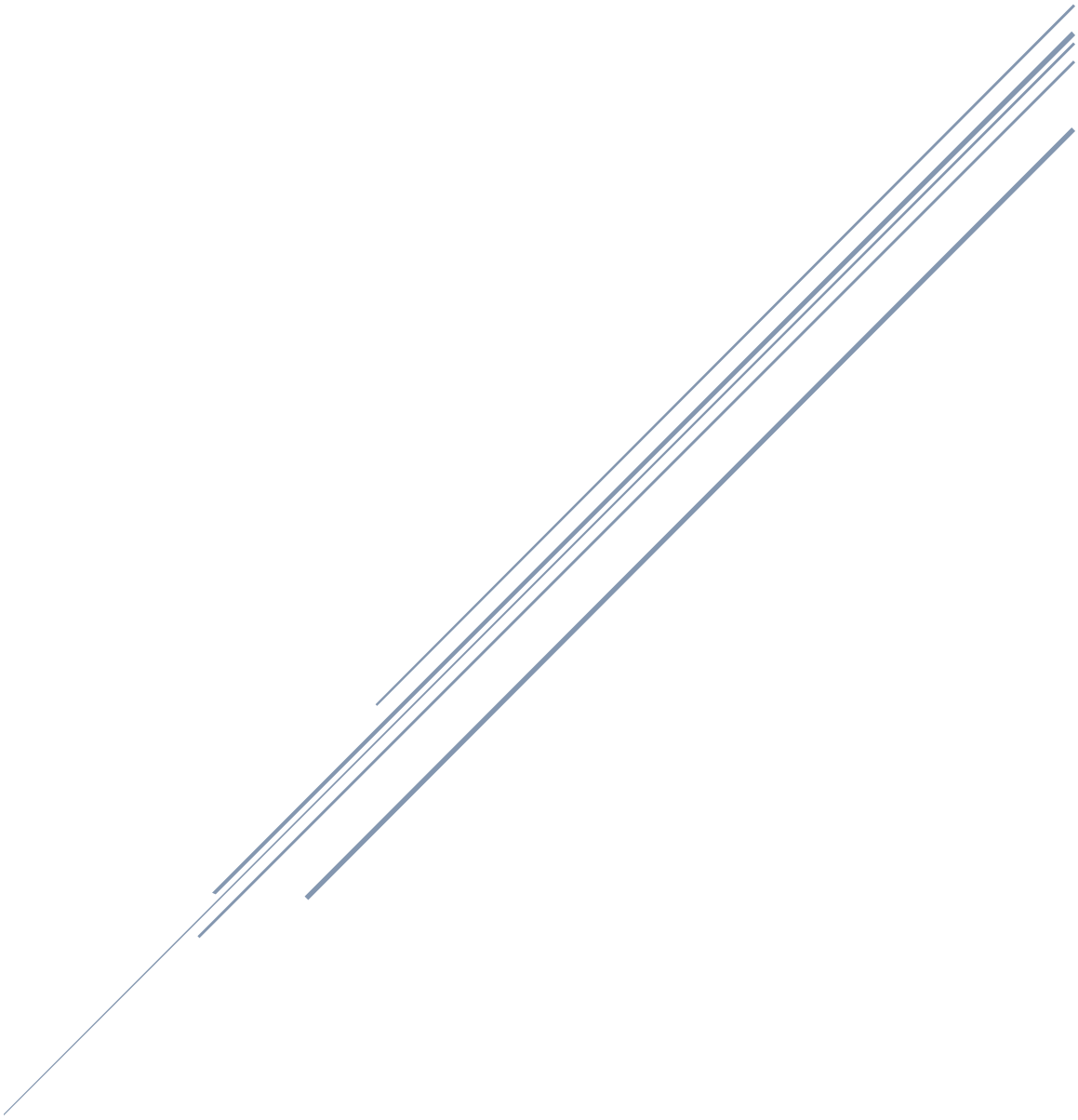
MANAGEMENT & LEADERSHIP

A COURSE READER For BSc Public Health



Professor Osama Awad Salih. School of Health Sciences, AUW. April 2026

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Note on Instructional Design & Technology These materials were developed through a collaborative process between **Professor Osama Awad Salih** and **Claude (Anthropic AI)**.

- **Human-AI Collaboration:** While AI was utilized to assist with structural drafting, formatting, and the generation of case study simulations, all technical content, pedagogical objectives, and Sudan-specific contextualization have been rigorously reviewed, edited, and validated by Professor Osama Awad Salih.
- **Final Authority:** The Professor remains the final authority on all academic claims and policy interpretations contained within this Reader.

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Management & Leadership of Health Programs | BSc Public Health

Session 1

Management & Leadership

Definitions, Concepts & Introduction to Program/Project Management

Ahfad University for Women | Topic One: Management & Leadership

Learning Outcomes — By the end of this session, students will be able to:
• Define management and explain its core purpose in a health Program context
• Identify and describe the four classical functions of management (POLC framework)
• Explain the key principles of management and their application in health settings
• Distinguish between a project and a Program and describe the Program management cycle
• Recognize the different levels of management and the skills required at each level

I. WHAT IS MANAGEMENT?

A. Definition

Management is the process of coordinating and overseeing the work of others so that organizational goals can be accomplished efficiently and effectively. In a health Program context, management means using available resources, people, money, time, information, and supplies to achieve defined health outcomes.

Term	Definition	Health Program Example
Efficiency	Doing things right, achieving maximum output with minimum resource waste	Delivering 1,000 antenatal care visits per month within the approved budget without stockouts or staff overtime
Effectiveness	Doing the right things, achieving the intended outcomes and goals	Reducing maternal mortality by 20% through targeted interventions, not just completing activities
Manager	A person responsible for planning, organizing, leading, and controlling resources to achieve goals	A district health officer overseeing a malaria control Program across 15 health centers

Key Point: *Efficiency and effectiveness are both essential — but effectiveness comes first. A manager who efficiently does the wrong thing is still failing the Program.*

B. Why Management Matters in Health Programs

Health Programs operate in environments of limited resources, complex needs, and high stakes. Poor management leads directly to poor health outcomes: essential medicines run out, staff are demoralized,

data is not collected, and communities lose trust. Good management creates the conditions in which health workers can do their best work.

Figure: Management links organizational inputs to health outcomes

II. THE FOUR FUNCTIONS OF MANAGEMENT — THE POLC FRAMEWORK

The most widely used framework for understanding what managers do is the POLC model — Planning, Organizing, Leading, and Controlling. These four functions are not sequential steps; they are ongoing, overlapping responsibilities that managers perform continuously:

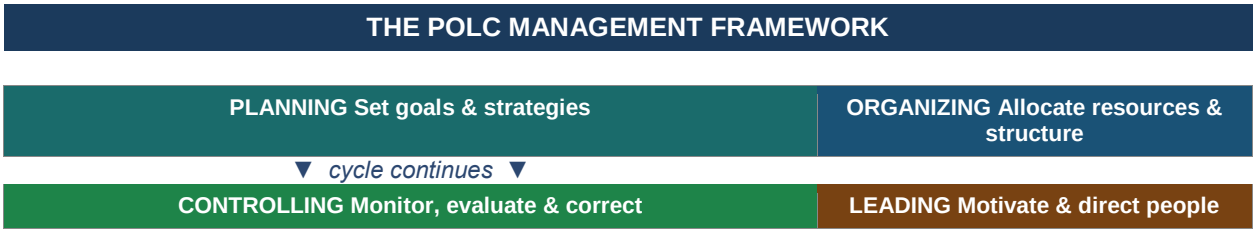
THE POLC MANAGEMENT FRAMEWORK
PLANNING Set goals & strategies
ORGANIZING Allocate resources & structure
cycle continues
CONTROLLING Monitor, evaluate & correct
LEADING Motivate & direct people

Figure: The four management functions operate as a continuous cycle — not a one-time sequence

A. Planning

Planning is the foundation of all management activity. It involves defining goals, establishing strategies to achieve them, and developing plans to coordinate activities. Without planning, organizations react to events rather than shaping them.

- Setting SMART objectives: Specific, Measurable, Achievable, Relevant, Time-bound
- Identifying resources required: staff, budget, equipment, supplies, time
- Anticipating risks and developing contingency plans
- Establishing timelines, milestones, and responsibilities

Example: *A district health manager planning an immunization campaign defines: target population (children under 5 in 10 villages), target coverage (95%), timeline (3 weeks), resources needed (vaccines, cold chain, outreach teams, transport), and contingency plan for cold chain failure.*

B. Organizing

Organizing is the process of arranging resources and tasks to accomplish the plan. It answers the question: 'Who does what, with what resources, and in what structure?' Organizing creates the structure through which plans are executed.

- Dividing work into specific tasks and assigning responsibilities
- Establishing the hierarchy and reporting relationships
- Delegating authority to appropriate levels
- Coordinating across departments and teams
- Ensuring resources are in the right place at the right time

C. Leading

Leading is the interpersonal dimension of management — motivating, directing, communicating with, and influencing people to work toward the organization's goals. Leading is where management comes closest to leadership (a distinction explored in Session 3).

- Communicating vision and goals clearly to all team members
- Motivating staff through recognition, support, and opportunity
- Making decisions and providing direction when challenges arise
- Building a positive and productive team culture
- Resolving conflicts and addressing performance issues

D. Controlling

Controlling is the process of monitoring performance, comparing it to planned targets, and taking corrective action when needed. Without controlling, managers cannot know whether their plans are working or whether resources are being used appropriately.

- Setting performance standards and benchmarks
- Collecting and analyzing performance data (supervision visits, reports, surveys)
- Comparing actual performance to planned targets
- Identifying deviations and diagnosing their causes
- Taking corrective action: retraining, reallocation, plan revision

Remember: *Controlling is not about distrust — it is about learning. Good managers use control data to improve systems, not to punish individuals.*

III. LEVELS OF MANAGEMENT

In any health organization or Program, management exists at multiple levels. Each level has different responsibilities, time horizons, and skill requirements:

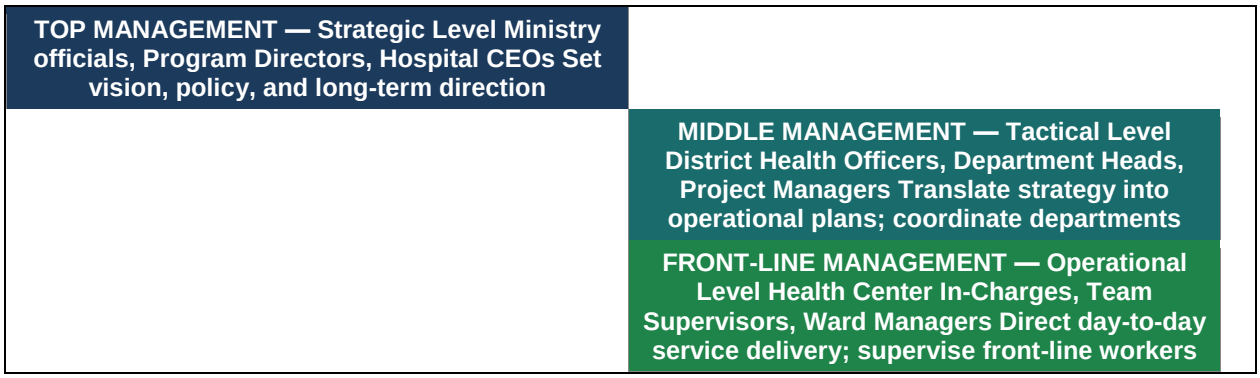
TOP MANAGEMENT — Strategic Level Ministry officials, Program Directors, Hospital CEOs Set vision, policy, and long-term direction
MIDDLE MANAGEMENT — Tactical Level District Health Officers, Department Heads, Project Managers Translate strategy into operational plans; coordinate departments
FRONT-LINE MANAGEMENT — Operational Level Health Center In-Charges, Team Supervisors, Ward Managers Direct day-to-day service delivery; supervise front-line workers

Figure: The three levels of management — each with distinct roles and time horizons

Management Level	Time Horizon	Primary Focus	Key Skills Required
Top (Strategic)	Long-term: 3–10 years	Vision, policy, organizational direction, external relations	Strategic thinking, political navigation, stakeholder management
Middle (Tactical)	Medium-term: 1–3 years	Translating strategy to plans, inter-departmental coordination, resource allocation	Planning, coordination, problem-solving, people management
Front-line (Operational)	Short-term: daily to monthly	Supervising staff, managing daily operations, service quality	Technical skills, supervision, communication, team leadership

Key Point: *A critical skill for any manager is knowing which level they are operating at — and adjusting their focus accordingly. A front-line manager who tries to set organizational strategy, or a top manager who micromanages daily operations, creates dysfunction at both levels.*

IV. PRINCIPLES OF MANAGEMENT

Henri Fayol (1916) identified 14 principles of management that remain highly relevant to health Program management today. The most important for health Program contexts are:

Fayol's Principle	Definition	Application in Health Programs
Division of Work	Specialize tasks to increase efficiency and skill	Assign specific roles: one nurse for antenatal care, another for immunization — each develops expertise
Authority & Responsibility	Managers must have authority commensurate with their responsibility	A district health officer responsible for Program outcomes must have authority to deploy staff and resources accordingly
Unity of Command	Each employee should receive orders from only one supervisor	A community health worker reports to one supervisor — not conflicting instructions from multiple sources
Unity of Direction	Activities with the same goal should be directed by one manager with one plan	All malaria control activities in a district coordinated under one district malaria Program plan
Subordination of Individual Interest	Organizational goals take precedence over individual preferences	Staff scheduling decisions should be based on patient needs, not solely on staff convenience
Scalar Chain	A clear line of authority from top to bottom	Clear reporting line: Community Health Worker → Health Center In-Charge → District Officer → State Ministry
Equity	Managers should be fair and impartial with all subordinates	Performance-based recognition applied consistently regardless of personal relationships
Initiative	Encourage staff to show initiative within their scope	Allow health workers to suggest solutions to local health problems and act on them with appropriate oversight

V. INTRODUCTION TO PROJECT AND PROGRAM MANAGEMENT

A. Project vs. Program — Key Distinctions

In health settings, the terms 'project' and 'Program' are often used interchangeably but have distinct meanings. Understanding the difference is essential for applying the right management approaches:

PROJECT	PROGRAM
• Temporary, has a defined start and end date	• Ongoing, sustained over multiple years
• Specific, bounded objectives and deliverables	• Broad strategic goals; multiple components
• Unique, one-time undertaking	• Comprised of multiple related projects
• Managed by a Project Manager	• Managed by a Program Manager/Director
• Budget allocated for defined activities	• Annual budget cycles with multi-year planning
• Example: Building a new health center	• Example: National Malaria Control Program
• Example: Conducting a vaccination campaign	• Example: Reproductive Health Program

Figure: Projects vs. Programs — key distinguishing characteristics

B. The Program Management Cycle

Effective health Program management follows a structured cycle of phases. Each phase builds on the previous one, and the cycle repeats as Programs are reviewed and renewed. This cycle is the operational backbone of all health Program management:

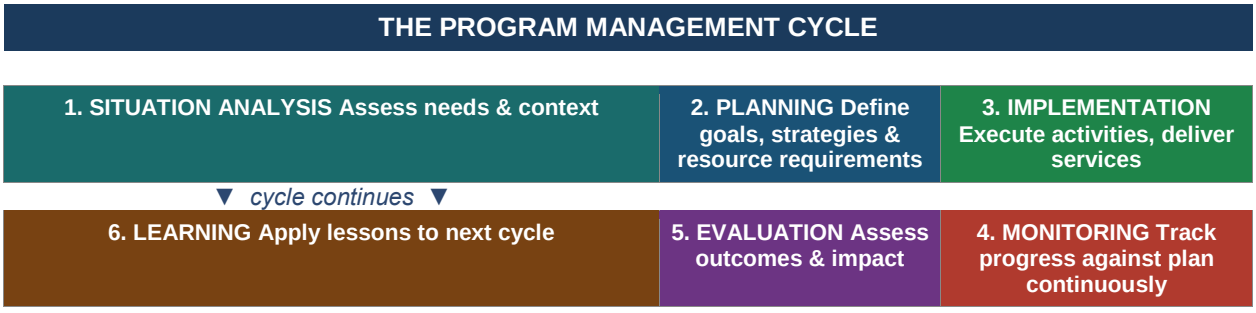
THE PROGRAM MANAGEMENT CYCLE
1. SITUATION ANALYSIS Assess needs & context
2. PLANNING Define goals, strategies & resource requirements
3. IMPLEMENTATION Execute activities, deliver services
▼ cycle continues ▼
6. LEARNING Apply lessons to next cycle
5. EVALUATION Assess outcomes & impact
4. MONITORING Track progress against plan continuously

Figure: The Program Management Cycle — a continuous process of planning, action, and learning

Cycle Phase	Key Management Questions	Key Tools & Methods
Situation Analysis	What is the health problem? Who is affected? What are the causes? What resources exist?	Needs assessments, epidemiological data, stakeholder analysis, SWOT analysis
Planning	What do we want to achieve? How will we get there? Who does what, by when, with what budget?	Theory of Change, LogFrame, work plans, budget plans, risk registers
Implementation	Are activities being executed as planned? Are resources being used appropriately?	Work plan tracking, procurement management, staff deployment, coordination meetings
Monitoring	Are we on track? Are we reaching our targets? Where are the gaps?	Routine data collection, supervision, dashboard reviews, spot checks
Evaluation	Did we achieve our outcomes? What worked and what did not? Why?	Surveys, focus groups, key informant interviews, pre-post comparisons
Learning & Adaptation	What should we do differently next cycle? How do we embed lessons?	After-action reviews, learning workshops, plan revisions, policy briefs

Case Study: Managing a District Immunization Program in Sudan

- Background: A district health officer in North Kordofan state is responsible for achieving 90% immunization coverage for children under 2 years across 20 health facilities. Current coverage is 65% and cold chain failures are frequent.
- Planning function: She reviews coverage data by facility, identifies the 6 lowest-performing facilities, and develops a targeted outreach plan. She prepares a budget request for cold chain repair and mobile vaccine carriers.
- Organizing function: She assigns a dedicated cold chain officer, creates an outreach roster for community health workers, and coordinates with the logistics team for vehicle scheduling.
- Leading function: She holds a team meeting, shares the coverage data transparently, and asks staff for their ideas on overcoming barriers. She Recognizes two health workers for their outreach performance publicly.
- Controlling function: She introduces a weekly facility report card tracking coverage by vaccine type, and conducts fortnightly supervisory visits to the 6 priority facilities.
- Discussion: Which of the four POLC functions do you think is most challenging in this context, and why? What management principles from Fayol's list are most visible in this case?

Reflection / Discussion Questions

- Think of a health Program or health facility you are familiar with. Identify one example of each POLC function in action, or identify which function appears to be weakest and why.
- What is the difference between managing a 3-month vaccination campaign (project) and managing a national immunization Program (Program)? What management challenges are unique to each?
- Fayol developed his management principles in 1916 for industrial factories. Which principles do you think apply most and least directly to managing a health Program in a resource-limited setting like Sudan? Justify your answer.

Session Summary — Key Takeaways

- Management is the process of coordinating resources (people, money, time, supplies) to achieve organizational goals efficiently and effectively. Both efficiency AND effectiveness are required, doing the right things, done right
- The POLC framework defines the four core functions of management: Planning (setting goals and strategies), Organizing (allocating resources and structure), Leading (motivating and directing people), and Controlling (monitoring, comparing, and correcting)
- Management exists at three levels, strategic (top), tactical (middle), and operational (front-line), each with different time horizons, responsibilities, and skill requirements
- Fayol's principles of management (division of work, authority & responsibility, unity of command, equity, initiative) remain highly applicable to health Program contexts despite their industrial origin
- Projects are temporary, bounded, and unique; Programs are sustained, multi-component, and ongoing. Both follow a management cycle: Situation Analysis → Planning → Implementation → Monitoring → Evaluation → Learning
- Good management in health Programs creates the organizational conditions that allow health workers to deliver quality services, directly contributing to health outcomes for communities

Suggested Reading:

1. Robbins SP & Coulter M (2018). Management, 14th Ed. Chapters 1-2. |
2. MSH (2008). Managers Who Lead — Chapter 1: What Managers Do. |
3. WHO (2007). Everybody's Business — Strengthening Health Systems. |
4. Fayol H (1949). General and Industrial Management (English translation).

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Session 2

Managerial Decision-Making

Steps, Models, Styles & Tools for Effective Decisions in Health Management

Ahfad University for Women | Topic One: Management & Leadership

Learning Outcomes

- Define decision-making and explain its central importance in health Program management
- Identify and apply the seven steps of the rational decision-making process
- Distinguish between Programed and non-Programed decisions and select appropriate approaches for each
- Compare major decision-making models: rational, bounded rationality, and intuitive
- Describe common cognitive biases and organizational barriers that impair decision quality
- Apply practical decision-making tools (decision matrix, force field analysis, cost-benefit analysis) to health management scenarios

I. WHAT IS DECISION-MAKING?

A. Definition and Centrality to Management

Decision-making is the process of identifying and selecting a course of action from among alternatives to solve a problem or seize an opportunity. It is the most fundamental managerial activity, every management function (planning, organizing, leading, controlling) requires decisions. A manager who cannot make timely, sound decisions cannot manage effectively.

In health Programs, poor decisions have direct consequences for patient safety, service quality, staff wellbeing, and resource use. A decision to delay ordering essential medicines, or to assign an unqualified staff member to a clinical task, or to ignore deteriorating performance data — all carry real health costs.

Type of Decision	Who Makes It	Examples in Health Management
Strategic decisions	Top management (ministry, directors)	Which diseases to priorities; whether to expand a Program to new regions; major resource allocation across budget lines
Tactical decisions	Middle management (district officers, Program managers)	How to deploy staff across facilities; which outreach strategy to use; how to address a supply chain bottleneck
Operational decisions	Front-line managers (in-charges, supervisors)	Daily staff scheduling; responding to an equipment failure; managing a patient complaint

Key Point: *Decision-making quality is not about speed — it is about using the right process, the right information, and the right people for the type and urgency of the decision at hand.*

II. THE SEVEN STEPS OF RATIONAL DECISION-MAKING

The rational decision-making model provides a structured, systematic approach to making complex decisions. It is the normative standard — the way decisions should be made when time, information, and cognitive capacity permit. The seven steps are:

1	STEP 1 — IDENTIFY AND DEFINE THE PROBLEM Clearly state what decision needs to be made and why. Distinguish symptoms from root causes. A wrong problem definition guarantees a wrong solution. Health example: 'Immunization coverage dropped from 85% to 62% in the last quarter — what is causing this and what do we do?'
▼	
2	STEP 2 — ESTABLISH DECISION CRITERIA Identify the criteria (standards, values, constraints) that the chosen alternative must satisfy. Criteria should be weighted by importance. Health example: Any solution must be: (1) achievable within current budget; (2) implementable within 4 weeks; (3) not require additional staff; (4) sustainable beyond the project period.
▼	
3	STEP 3 — IDENTIFY ALL POSSIBLE ALTERNATIVES Generate a comprehensive set of potential options without premature evaluation. Involve staff with relevant knowledge. Avoid anchoring on the first idea. Health example: Options include, additional outreach teams; community health worker training; community leader engagement; social media campaign; mobile vaccination clinics.
▼	
4	STEP 4 — EVALUATE EACH ALTERNATIVE AGAINST CRITERIA Systematically assess each option against the decision criteria established in Step 2. Use available data, cost estimates, and experience. Health example: Score each option on feasibility, cost, speed, and sustainability on a 1-5 scale to create a decision matrix.
▼	
5	STEP 5 — SELECT THE BEST ALTERNATIVE Choose the option that best satisfies the weighted decision criteria. If no single option is dominant, consider combining elements of multiple options. Health example: Community health worker training + mobile clinics scores highest across all four criteria and is selected.
▼	
6	STEP 6 — IMPLEMENT THE DECISION Develop an implementation plan: who does what, by when, with what resources. Communicate the decision clearly to all involved parties. Assign accountability. Health example: Assign a focal person; schedule training for next week; deploy mobile clinic on a defined route; brief community leaders.
▼	
7	STEP 7 — EVALUATE THE OUTCOME Monitor whether the decision achieved its intended effect. If not, cycle back to re-diagnose. Decision-making is iterative, not a one-time event. Health example: Review coverage data after 6 weeks. If coverage recovers to >80%, the decision was effective. If not, return to Step 1.

Figure: The 7-Step Rational Decision-Making Process — applied to a health Program coverage problem

III. TYPES OF DECISIONS

A. Programed vs. Non-Programed Decisions

Not all decisions are equal in complexity or novelty. Understanding the type of decision helps managers choose the right approach and level of analysis:

Dimension	Programed Decisions	Non-Programed Decisions
Definition	Routine, repetitive decisions handled by established rules, policies, or standard procedures	Novel, complex, or unique decisions without established procedures; require fresh analysis
Certainty	High certainty, situation is well understood	High uncertainty, situation may be ambiguous or unprecedented
Approach	Apply existing policy, protocol, or standard operating procedure	Apply the rational 7-step model; consult experts; involve stakeholders
Time required	Quick, rules already exist	Substantial, requires analysis, consultation, and judgement
Health examples	Drug stockout triggers reorder protocol; patient referral follows established criteria; staff leave granted per HR policy	Responding to a disease outbreak in a previously unaffected area; deciding whether to close a health facility; redesigning a Program strategy after poor evaluation results
Management level	Primarily operational/front-line	Primarily strategic/middle management

Remember: *A common management error is treating a non-Programed decision as if it were Programed — applying a routine response to a novel problem. This produces poor outcomes. Conversely, spending hours deliberating over a routine decision wastes management time. Match the process to the decision type.*

IV. DECISION-MAKING MODELS

A. The Rational Model

The rational model (as described in the 7-step process above) assumes decision-makers have access to complete information, can evaluate all alternatives objectively, and will select the option that maximizes the desired outcome. It provides the gold standard of decision quality but has important limitations in real-world health management.

Rational Model	Strengths	Limitations in Health Contexts
Assumption: Complete information	Produces theoretically optimal decisions when information is available	Health managers rarely have complete, reliable data, especially in low-resource or conflict settings
Assumption: Objective evaluation	Removes bias and personal preference from the decision	Cognitive biases (see Section V) and political pressures distort evaluation in practice
Assumption: Maximizing outcome	Selects the best possible solution, not just an acceptable one	Time constraints, resource limitations, and organizational politics often prevent the 'best' solution from being implementable

B. Bounded Rationality (Herbert Simon, 1955)

Herbert Simon observed that real decision-makers do not maximize, they satisfice. Bounded rationality Recognizes that human cognitive capacity is limited, information is incomplete, and time is short. Managers make decisions that are 'good enough' rather than optimal:

- Decision-makers work within cognitive limits; they cannot process all information or evaluate all alternatives
- They establish a minimum acceptable standard (aspiration level) and select the first option that meets it
- This produces satisfactory but not necessarily optimal decisions, which is often entirely appropriate given real-world constraints
- Implication for health managers: Build decision-support tools (checklists, standard protocols, decision trees) that help bounded humans make consistently good decisions without requiring complete information

Example: *A district health officer facing a staffing shortage does not analyses every possible deployment scenario, she applies a known prioritization rule: cover facilities with highest patient volume first. This is bounded rationality producing a consistently reasonable decision quickly.*

C. Intuitive Decision-Making

Experienced managers often make fast, effective decisions that appear to bypass systematic analysis — this is intuitive decision-making. Research shows that intuition is not guesswork; it is pattern recognition built from extensive experience:

- Expert intuition is based on recognizing familiar patterns in new situations, the experienced clinician who 'knows' something is wrong before the data confirms it
- Intuition is appropriate for: time-critical decisions; well-defined problem domains where the manager has deep experience; situations where data is unavailable
- Intuition is NOT appropriate for: novel situations without precedent; high-stakes decisions with significant uncertainty; situations where the manager lacks relevant experience

Key Point: *Effective managers develop both analytical and intuitive decision-making capabilities. The best managers know when to use each — and when to combine them. Intuition provides the direction; analysis provides the validation.*

V. DECISION CONDITIONS AND UNCERTAINTY

A. Three Decision Environments

Decisions are made in different conditions of certainty. Understanding the decision environment shapes the appropriate level of analysis and the tolerance for risk:

	OUTCOMES KNOWN	OUTCOMES UNKNOWN
HIGH INFO	CERTAINTY All outcomes known with confidence Apply standard procedures Low analysis required	RISK Outcomes probabilistic — known probability distribution Use expected value analysis Develop contingency plans
LOW INFO	UNCERTAINTY Probabilities unknown Use scenario planning Apply precautionary principle	AMBIGUITY Problem itself is unclear Seek more information first Involve diverse stakeholders

Figure: Decision conditions matrix — information availability vs. outcome knowledge

Most real health management decisions fall under risk or uncertainty, not certainty. Managers must develop comfort with incomplete information and the ability to make sound decisions without waiting for perfect data.

VI. COGNITIVE BIASES IN DECISION-MAKING

Even experienced managers are susceptible to systematic errors in thinking that impair decision quality. These cognitive biases are not signs of incompetence, they are built into human cognition. Awareness is the first step to mitigation:

Cognitive Bias	Definition	Health Management Example	Mitigation Strategy
Anchoring bias	Over-relying on the first piece of information encountered	Assuming this year's budget should be 'about the same' as last year without examining actual needs	Start with needs assessment, not last year's budget; actively seek alternative reference points
Confirmation bias	Seeking information that confirms existing beliefs and ignoring contradicting evidence	Dismissing a supervision report showing poor quality because 'our Program is performing well'	Actively seek out contradicting data; assign a 'devil's advocate' role in team discussions
Availability bias	Over-weighting information that is easily recalled or recent	Over-prioritizing a disease because of a recent outbreak, while neglecting a higher-burden chronic condition	Use systematic epidemiological data rather than relying on recent memorable events
Groupthink	Team members suppress dissent to maintain group harmony, producing poor collective decisions	A management team unanimously approves a plan because no one wants to challenge the director	Create psychological safety; explicitly ask for concerns; consider anonymous input mechanisms
Sunk cost fallacy	Continuing a failing course of action because of resources already invested	Continuing a poorly performing Program because 'we have already spent three years on it'	Evaluate decisions based on future costs and benefits — not past investments that cannot be recovered
Overconfidence bias	Overestimating the accuracy of one's own judgements	A manager setting an immunization target of 95% in 3 months with no evidence this is achievable	Seek external validation; use historical benchmarks; build in contingency for uncertainty

VII. PRACTICAL DECISION-MAKING TOOLS

A. The Decision Matrix

A decision matrix provides a structured, quantitative method for evaluating multiple alternatives against multiple weighted criteria. It converts subjective judgements into comparable scores and is particularly useful for complex decisions involving several options:

Criteria (with Weight)	Option A: Community Health Workers (Score 1-5)	Option B: Mobile Clinics (Score 1-5)	Option C: Media Campaign (Score 1-5)
Cost (Weight: 30%)	4 (Weighted: 1.2)	2 (Weighted: 0.6)	3 (Weighted: 0.9)
Speed of impact (Weight: 25%)	3 (Weighted: 0.75)	4 (Weighted: 1.0)	2 (Weighted: 0.5)
Sustainability (Weight: 25%)	5 (Weighted: 1.25)	2 (Weighted: 0.5)	3 (Weighted: 0.75)
Community acceptance (Weight: 20%)	5 (Weighted: 1.0)	3 (Weighted: 0.6)	4 (Weighted: 0.8)
TOTAL WEIGHTED SCORE	4.20 ★ HIGHEST	2.70	2.95

Key Point: *In this example, Option A (Community Health Workers) scores highest across weighted criteria and is the recommended choice. The matrix makes the reasoning transparent and defensible, important when the decision must be communicated to stakeholders.*

B. Force Field Analysis (Kurt Lewin)

Force Field Analysis maps the driving forces (pushing toward a desired change) and restraining forces (resisting the change) that will determine whether a decision or initiative succeeds. It helps managers anticipate resistance and plan accordingly:

DRIVING FORCES (for change)	Strength	RESTRAINING FORCES (against change)	Strength
Strong evidence that community health workers improve coverage	High	Staff resistance to new supervisory requirements	Medium
Low cost compared to alternatives	High	Lack of transport for volunteer CHWs	High
Community leader support already secured	Medium	Previous bad experience with similar Program	Medium
Ministry policy priority for community-based services	Medium	Delay in training materials procurement	Low

Lewin's prescription: to achieve change, either strengthen driving forces OR weaken restraining forces (or both). In the example above, the transport barrier is high-strength, the implementation plan must address it directly or the decision will fail.

C. Cost-Benefit Analysis (CBA)

Cost-Benefit Analysis compares the estimated costs of an option against its estimated benefits to determine economic value. In health management, benefits are typically expressed in health outcomes (lives saved, illness prevented) or economic value:

- Identify all costs: direct costs (staff, supplies, equipment, training), indirect costs (management time, opportunity cost), and recurrent costs
- Identify all benefits: health outcomes (cases averted, deaths prevented), productivity gains, reduced future costs
- Calculate the Benefit-Cost Ratio (BCR): BCR = Total Benefits / Total Costs. BCR >1 means benefits outweigh costs, the intervention creates net value
- Consider the time horizon: benefits of health interventions often accrue over years; discount future benefits appropriately

Example: *A community health worker Program costs USD 50,000/year and prevents an estimated 120 child deaths annually (valued at USD 5,000 per life-year saved = USD 600,000 in health value). BCR = 600,000/50,000 = 12:1. This is an extremely high-return investment.*

VIII. GROUP AND PARTICIPATORY DECISION-MAKING

Many important health management decisions should not be made by one person alone. Group decision-making improves quality when: the problem is complex; diverse expertise is needed; implementation requires buy-in from multiple stakeholders. However, group decisions also carry risks (groupthink, slow process) that must be managed:

Technique	When to Use	Process	Advantage
Brainstorming	Generating creative alternatives; early-stage problem-solving	Group generates ideas freely no criticism allowed during idea generation phase; all ideas recorded; then group evaluates	Maximizes idea generation; prevents premature closure on first idea
Nominal Group Technique (NGT)	Ensuring all voices are heard; avoiding dominance by senior members	Each person silently generates ideas; round-robin sharing; group discussion; anonymous voting on priorities	Structured equality; reduces seniority bias; produces ranked priorities
Delphi Technique	Synthesizing expert opinion without meeting face-to-face; reducing social influence	Multiple rounds of anonymous questionnaires; responses shared back; consensus emerging over rounds	Useful for geographically dispersed teams; eliminates social pressure; produces stable consensus
Multi-voting	Narrowing a long list of options to a manageable short list	Each participant gets a fixed number of votes (e.g., 5) to allocate across options; highest-scoring options advance	Fast, democratic, and transparent prioritization

Case Study: A Drug Stockout Crisis — Decision Under Pressure

- Situation: A health center in-charge arrives Monday morning to find that the facility has run out of oral rehydration salts (ORS) and antibiotics for childhood diarrhoea — critical medicines during the peak diarrhoea season. The district store is 60 km away and the facility vehicle is under repair.
- Applying the 7 steps:
- Step 1 — Problem: No ORS or antibiotics available; children presenting with acute diarrhoea need immediate treatment.
- Step 2 — Criteria: Solution must be implemented within hours (not days); must obtain real medicines (not substitutes); must not create new supply chain violations.
- Step 3 — Alternatives: (a) Borrow from nearest facility 15 km away; (b) Request emergency dispatch from district using public transport; (c) Refer all patients to district hospital; (d) Contact NGO operating in area for emergency supplies.
- Step 4 — Evaluate: Option (a) is fastest and maintains care locally. Option (c) risks overwhelming district hospital. Options (b) and (d) are viable backups.
- Steps 5-7 — Decision & follow-up: Immediately borrow from nearest facility AND simultaneously alert district of stockout to prevent recurrence. Document the stockout to trigger review of reorder system.
- Discussion: What type of decision was this (Programed or non-Programed)? Which decision-making biases might have impaired the response? What system change would prevent this decision from being needed again?

Reflection / Discussion Questions

- Recall a significant management decision you have witnessed or read about in a health Program. Walk through the 7-step rational model in reverse — which steps were done well and which were skipped? What was the consequence?
- A hospital director needs to decide whether to close a low-performing maternity ward and consolidate services at the main facility 20 km away. What type of decision is this? What decision-making model would you recommend? Who should be involved in the decision and why?
- Of the six cognitive biases described in this session, which do you think is most dangerous in health Program management and why? What specific organizational practice could be introduced to counteract it?

Session Summary — Key Takeaways

- Decision-making is the most fundamental managerial activity — every management function requires it. Decisions exist at three levels: strategic (top management), tactical (middle management), and operational (front-line management)
- The 7-step rational model: (1) Define the problem, (2) Establish criteria, (3) Identify alternatives, (4) Evaluate alternatives, (5) Select the best option, (6) Implement, (7) Evaluate outcomes. It is the gold standard for complex, non-Programed decisions
- Programed decisions use established rules and procedures; non-Programed decisions require the full rational process. Matching the decision approach to the decision type is itself a key management skill

- Three decision models: Rational (maximize — ideal but rarely fully achievable), Bounded Rationality (satisfice — good enough given real constraints), Intuitive (expert pattern recognition — appropriate for experienced managers in familiar domains)
- Six critical cognitive biases impair decision quality: anchoring, confirmation, availability, groupthink, sunk cost fallacy, and overconfidence. Awareness and deliberate countermeasures (data review, devil's advocates, anonymous input) reduce their impact
- Practical tools: Decision Matrix (weighted scoring of alternatives), Force Field Analysis (driving vs. restraining forces), Cost-Benefit Analysis (BCR = benefits/costs). Group techniques: Brainstorming, Nominal Group, Delphi, Multi-voting

Suggested Reading:

1. Robbins SP & Coulter M (2018). Management, 14th Ed. Chapter 6: Decision Making. |
2. Simon HA (1955). A Behavioral Model of Rational Choice. Quarterly Journal of Economics. | Kahneman D (2011). Thinking, Fast and Slow. Chapters 11-14. |
3. MSH (2008). Managers Who Lead — Chapter 4.

Management & Leadership of Health Programs | BSc Public Health

Session 3

Manager vs. Leader & Management/Leadership Styles

Distinguishing Roles, Understanding Styles, and Knowing When to Apply Each

Ahfad University for Women | Topic One: Management & Leadership

Learning Outcomes

- Clearly distinguish between the roles of a manager and a leader in a health Program context
- Explain why health Programs need both management and leadership — and why neither alone is sufficient
- Describe the major leadership styles: autocratic, democratic, laissez-faire, transactional, and transformational
- Apply the Situational Leadership model to select the appropriate style for different staff and contexts
- Identify your own dominant leadership tendencies and reflect on areas for development
- Recognize the characteristics of an effective health Program leader and manager

I. MANAGER VS. LEADER — A FUNDAMENTAL DISTINCTION

A. Are They the Same Person?

One of the most important and most debated, questions in organizational theory is: what is the difference between a manager and a leader? In practice, the same person often performs both roles. But the two are conceptually distinct, and confusing them leads to organizations that are either over-managed and under-led, or over-led and under-managed. Both failures are dangerous in health Programs.

Quote: *'Managers do things right. Leaders do the right things.' — Warren Bennis & Peter Drucker*

Quote: *'Management is efficiency in climbing the ladder of success; leadership determines whether the ladder is leaning against the right wall.' — Stephen Covey*

THE MANAGER	THE LEADER
• Focuses on systems, structures, and processes	• Focuses on vision, people, and change
• Plans and budgets for short-to-medium term	• Sets direction for the long term
• Organizes and staffs, puts right people in right roles	• Aligns people, communicates vision and builds coalitions
• Controls and problem-solves, keeps the system on track	• Motivates and inspires, energizes people to overcome barriers
• Asks: HOW and WHEN?	• Asks: WHAT and WHY?

• Works within established boundaries	• Challenges and changes boundaries when necessary
• Maintains and improves current systems	• Innovates and transforms
• Authority comes from position (formal power)	• Authority comes from influence (personal power)
• Produces order, consistency, and predictability	• Produces change, movement, and transformation
• Manages complexity in existing operations	• Manages complexity in uncertain, changing environments

Figure: Manager vs. Leader — complementary but distinct roles (Kotter, 1990)

Key Point: *Health Programs need BOTH. A Program with excellent management but no leadership executes perfectly toward the wrong goals. A Program with inspirational leadership but poor management fails to deliver services reliably. The ideal health Program manager-leader does both — and knows which mode the situation calls for.*

II. MANAGEMENT STYLES

A. The Classic Three: Autocratic, Democratic, Laissez-Faire

Kurt Lewin's research in the 1930s identified three fundamental management styles based on how decisions are made and how authority is exercised. These remain the foundational reference point for all subsequent style frameworks:

AUTOCRATIC (Authoritarian)	DEMOCRATIC (Participative)
• Manager makes all decisions alone • Little or no input from staff • Communication flows top-down • Close supervision of all work • Rewards and punishments control behaviour • High control, low staff autonomy	• Manager involves staff in decisions • Two-way communication and consultation • Final decision rests with manager • Staff have autonomy within guidelines • Encourages initiative and creativity • Moderate control, higher staff autonomy
LAISSEZ-FAIRE (Delegative)	**WHEN EACH IS APPROPRIATE**
• Manager delegates most decisions to staff • Minimal direction or supervision • Staff work largely independently • Manager acts as resource, not director • Works only with highly skilled, motivated teams • Low control, very high staff autonomy	• Autocratic: Crisis/emergency; new/unskilled staff; safety-critical situations • Democratic: Complex problems requiring expertise; building team buy-in; experienced staff • Laissez-faire: Expert professionals; research teams; highly self-motivated staff

Figure: Three classic management styles — Lewin's framework with health Program application

Style	Advantages	Disadvantages	Health Program Example
Autocratic	Fast decisions; clear accountability; effective in crisis	Kills initiative; lowers morale; creates dependency; staff turnover	Emergency response to an outbreak where speed is critical and roles must be clear
Democratic	Higher quality decisions; builds commitment; develops staff capacity	Slow process; can create conflict; ineffective with unskilled staff	Program strategy revision with experienced team; policy development with multi-sector stakeholders
Laissez-faire	Maximizes expert autonomy; high creativity; suits professionals	Fails with unmotivated/unskilled staff; creates chaos without structure	Supervising a research team of qualified epidemiologists; leading a team of senior specialist consultants

III. LEADERSHIP STYLES — TRANSACTIONAL VS. TRANSFORMATIONAL

A. Transactional Leadership

Transactional leadership is based on an exchange — the leader provides rewards (pay, promotion, recognition) in return for follower compliance and performance. It is the dominant mode in most formal organizations and is effective for maintaining stability and meeting established standards:

- Based on clearly defined roles, expectations, and performance standards
- Rewards for meeting targets; consequences for failure
- Works well when tasks are clear, work is routine, and incentive systems function
- Limitations: does not inspire beyond minimum expected performance; does not build loyalty or commitment to a larger purpose; fails in environments where intrinsic motivation matters

Example: *A health facility manager who issues monthly performance reports, recognizes staff who meet immunization targets with certificates, and addresses those who do not through the formal supervision system is applying transactional leadership.*

B. Transformational Leadership

Transformational leadership (Burns, 1978; Bass, 1985) goes beyond exchange — it inspires followers to transcend their own self-interest for a higher collective purpose. Transformational leaders change how followers think and what they value, producing extraordinary commitment and performance:

The 4 I's of Transformational Leadership	Description	Health Program Application
Idealized Influence (Charisma)	The leader models the values, ethics, and commitment they expect from followers. Followers want to identify with and emulate the leader	A Program director who works alongside field teams during crises, maintains integrity under donor pressure, and is visibly committed to the Program's health mission
Inspirational Motivation	The leader articulates a compelling vision of the future that energizes followers. Creates meaning and purpose beyond the immediate task	Communicating powerfully that 'every child we vaccinate is a child who will grow up healthy enough to shape Sudan's future' — connecting daily work to a larger purpose
Intellectual Stimulation	The leader challenges followers to question assumptions, think creatively, and approach problems in new ways. Creates a learning culture	Asking the team 'Why are we still doing outreach the same way we did five years ago?' — encouraging innovation in service delivery models
Individualized Consideration	The leader pays attention to each follower's unique needs, strengths, and developmental stage. Acts as mentor and coach	Recognizing that one staff member needs more autonomy while another needs more support; providing tailored feedback rather than generic performance reviews

Key Point: *Transformational leadership produces significantly better outcomes in complex, changing, and resource-constrained environments — which describes most health Programs. However, transformational leadership without management systems creates inspired chaos. The best health Program leaders combine transformational inspiration with sound management discipline.*

IV. THE SITUATIONAL LEADERSHIP MODEL (Hersey & Blanchard)

The most practically useful leadership framework for health Program managers is Situational Leadership (Hersey & Blanchard, 1969). Its central insight is that there is no single best leadership style the effective style depends on the readiness (competence + commitment) of the follower for the specific task:

Follower Readiness Level	Competence	Commitment	Appropriate Leadership Style	Style Description
R1 — Unable & Unwilling or Insecure	Low	Low or variable	S1: TELLING / DIRECTING	High task direction, low relationship support. Give specific instructions; closely supervise; do not yet delegate. Example: New health worker on their first day
R2 — Unable but Willing or Motivated	Low	High	S2: SELLING / COACHING	High task direction AND high relationship support. Explain decisions; build confidence; provide

				encouragement alongside guidance. Example: Enthusiastic new graduate who lacks experience
R3 — Able but Unwilling or Insecure	High	Variable or low	S3: PARTICIPATING / SUPPORTING	Low task direction, high relationship support. Listen; involve in decisions; provide encouragement; let them lead. Example: Experienced nurse who lacks confidence to lead outreach
R4 — Able and Willing or Confident	High	High	S4: DELEGATING	Low task direction, low relationship support. Assign responsibility; monitor from a distance; trust their judgement. Example: Senior Program officer with proven track record

Figure: Situational Leadership continuum — leadership style shifts with follower readiness (Hersey & Blanchard)

Remember: *A critical mistake is applying the same style to all staff. The experienced clinician and the new graduate require completely different leadership approaches — even for the same task. Situational leaders continuously assess each person's readiness for each task and adjust their style accordingly.*

V. OTHER IMPORTANT LEADERSHIP CONCEPTS

A. Servant Leadership (Robert Greenleaf, 1970)

Servant leadership inverts the traditional authority pyramid: the leader exists to serve the needs of followers, not the other way around. The servant leader's primary question is 'How can I help my team succeed?' rather than 'How can my team serve my goals?'

- Characteristics: empathy, listening, stewardship, commitment to the growth of people, building community
- Health Program application: A district health officer who removes bureaucratic barriers for front-line workers, advocates for their resource needs upward, and prioritizes their professional development is practicing servant leadership
- Research evidence: Servant leadership is consistently associated with higher team performance, lower turnover, and greater staff wellbeing, particularly important in mission-driven health organizations where intrinsic motivation matters

B. Emotional Intelligence (EI) in Leadership (Daniel Goleman)

Daniel Goleman's research showed that what distinguishes great leaders from average ones is not primarily technical expertise or IQ — it is Emotional Intelligence: the ability to understand and manage one's own emotions, and to understand and influence the emotions of others. EI has five components:

EI Component	Definition	Health Leadership Application
Self-awareness	Knowing one's own emotions, strengths, weaknesses, and their effect on others	A manager who Recognizes when stress is making her impatient and adjusts her communication accordingly before an important team meeting
Self-regulation	Controlling disruptive emotions; maintaining integrity under pressure; being comfortable with change	A Program director who receives bad evaluation results and responds with calm analysis rather than defensiveness or blame
Motivation	Internal drive to achieve; resilience; optimism even in adversity	A health worker who maintains commitment to patient care through months of difficult working conditions because of deep belief in the Program's mission
Empathy	Understanding others' emotional states; considering feelings in decision-making; developing others	A manager who Recognizes a high-performing staff member is overwhelmed and proactively reduces their workload before performance deteriorates
Social skills	Managing relationships; building networks; finding common ground; collaboration	A Program manager who successfully navigates the competing priorities of government, donors, and community leaders to maintain Program momentum

Key Point: *Goleman's research across 188 companies found that EI accounted for 90% of the difference between average and star performers in senior leadership positions. Technical and managerial skills matter — but they are threshold competencies. EI is what differentiates the best leaders.*

VI. POWER AND INFLUENCE IN MANAGEMENT AND LEADERSHIP

Both managers and leaders exercise power, the ability to influence others' behaviour. Understanding the sources of power helps health Program managers use influence ethically and effectively:

Source of Power	Basis	Health Program Example	Durability
Legitimate power	Formal authority from position in hierarchy	District health officer issues a directive that staff are expected to follow	Lasts only as long as the position is held
Reward power	Ability to give valued rewards (pay, recognition, promotion)	Manager recommends a high-performer for promotion or commendation	Depends on having real rewards to give; diminishes if rewards are not valued
Coercive power	Ability to punish or create negative consequences	Manager threatens disciplinary action for persistent absenteeism	Breeds resentment and compliance

			without commitment; undermines culture
Expert power	Influence based on knowledge, skills, and expertise	Experienced epidemiologist whose technical judgement is trusted and followed	Very durable — increases with demonstrated competence
Referent power	Influence based on being liked, admired, and respected — personal charisma	A leader whom staff follow because they genuinely respect and believe in them	Most durable of all — survives role changes; the basis of transformational leadership
Information power	Influence based on controlling access to important information	Staff depend on the Program officer who manages the HMIS for performance data	Vulnerable — diminishes as information becomes more widely available

Remember: *The most effective health leaders build expert power and referent power — they lead through competence and character, not just through their position title. Overreliance on legitimate or coercive power produces compliance, not commitment.*

Case Study: Dr. Fatima and the Immunization Team — A Leadership Style Challenge

- Background: Dr. Fatima is the newly appointed immunization Program manager for a state with 45 health facilities. Her team of 8 includes: two experienced senior officers (10+ years), three mid-level officers (3-5 years), two recent graduates (6 months), and one officer who is technically skilled but consistently disengaged and resistant to new initiatives.
- Challenge 1 — The experienced officers: They have excellent knowledge but feel marginalized by the previous manager's autocratic approach. Coverage in their districts is high but they seem to be operating on autopilot.
- Challenge 2 — The recent graduates: They are enthusiastic but make frequent procedural errors and need close guidance. One is particularly anxious about making mistakes.
- Challenge 3 — The disengaged officer: Technically capable but openly skeptical about new Program targets. Misses meetings. Has not submitted complete reports for 3 months.
- Question 1: Using the Situational Leadership model, identify the readiness level and appropriate leadership style for each of the three staff groups. Be specific about what Dr. Fatima should DO differently with each group.
- Question 2: Which of Goleman's five EI components would be most important for Dr. Fatima in managing the disengaged officer? What specific approach would you recommend?
- Question 3: What combination of management and leadership does Dr. Fatima need to apply to this team as a whole? Where does she need to be more of a manager, and where more of a leader?

Reflection / Discussion Questions

- Think of the best manager or leader you have encountered (in any context — health, community, family, sport). What specific behaviour made them effective? Which of the frameworks from this session (management styles, transformational leadership, situational leadership, EI) best explains what made them effective?
- Where on the manager-leader spectrum do you currently position yourself? What evidence supports your self-assessment? What would you need to develop to become more effective on the other end of the spectrum?
- A health center in-charge tells you: 'I treat all my staff the same — I give everyone the same clear instructions, the same supervision, and the same performance standards. That's fair.' Do you agree? Use the Situational Leadership model to analyse this approach.

Session Summary — Key Takeaways

- Managers and leaders are distinct but complementary roles: managers focus on systems, structures, efficiency, and consistency; leaders focus on vision, people, change, and inspiration. Health Programs need both — the best health Program professionals develop competence in both dimensions
- Three classic management styles: Autocratic (high control — effective in crisis, poor for development); Democratic (participative — effective for complex problems with capable teams); Laissez-faire (delegative — effective only with expert, self-motivated professionals). No style is universally best
- Transactional leadership motivates through reward-and-consequence exchange — effective for maintaining standards. Transformational leadership (the 4 I's: Idealized Influence, Inspirational Motivation, Intellectual Stimulation, Individualized Consideration) inspires extraordinary commitment — essential for mission-driven health work
- Situational Leadership (Hersey & Blanchard): match leadership style to follower readiness. R1 (low competence/commitment) → S1 Telling; R2 (low competence/high commitment) → S2 Coaching; R3 (high competence/variable commitment) → S3 Supporting; R4 (high competence/high commitment) → S4 Delegating
- Emotional Intelligence (Goleman) — five components: self-awareness, self-regulation, motivation, empathy, social skills — accounts for 90% of the difference between average and outstanding leaders. EI can be learned and developed
- Six sources of power: legitimate, reward, coercive, expert, referent, information. The most durable and effective leadership power bases are expert power (competence) and referent power (character). Over-reliance on coercive power produces compliance without commitment

Suggested Reading:

1. Kotter JP (1990). A Force for Change: How Leadership Differs from Management. |
2. Bass BM (1985). Leadership and Performance Beyond Expectations. |
3. Hersey P & Blanchard K (1969). Life Cycle Theory of Leadership. Training & Development Journal. |
4. Goleman D (1998). What Makes a Leader? Harvard Business Review. |
5. Greenleaf RK (1977). Servant Leadership. | MSH (2008). Managers Who Lead — Chapters 2 & 3.

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Session 4

Project & Program Design

From Needs Assessment to Theory of Change, LogFrame & Work Planning

Ahfad University for Women | Topic Two: Management Functions

Learning Outcomes
• Explain the purpose and components of a project/Program design process • Conduct a basic needs assessment and situational analysis using standard tools (problem tree, SWOT)
• Develop a Theory of Change (ToC) for a health Program, with causal pathways and assumptions • Construct a Logical Framework (LogFrame) matrix with goals, outputs, indicators, and means of verification
• Develop an operational work plan with timelines, responsibilities, and milestones • Identify and manage Program design risks using a risk register

I. WHAT IS PROGRAM DESIGN?

Program design is the structured process of defining what a health Program will do, how it will do it, why it will work, and how success will be measured, before implementation begins. A well-designed Program provides the roadmap that guides all subsequent management decisions: what to implement, when, with whom, and at what cost.

Poor Program design is the single most common cause of Program failure, not poor implementation. A Program that is well-implemented but poorly designed efficiently delivers the wrong intervention to the wrong people, or addresses symptoms rather than root causes. Good design takes time upfront and saves enormous resources downstream.

Figure: The Program design process — six sequential components

II. SITUATION ANALYSIS — UNDERSTANDING THE CONTEXT

A. Needs Assessment

Before designing any intervention, managers must understand the health situation, its causes, and the context in which the Program will operate. A needs assessment answers: Who is affected? How severely? What are the causes? What resources already exist? What gaps remain?

Needs Assessment Component	Key Questions	Data Sources
Epidemiological profile	What is the burden of the health problem? Who is most affected (age, sex, geography, socioeconomic group)? What are the trends?	Health facility records; national surveys; disease surveillance data; WHO/UNICEF country profiles
Causal analysis	What are the immediate, underlying, and structural causes of the problem? What is driving it?	Literature review; focus group discussions; key informant interviews; community consultations
Existing services & gaps	What services currently exist? Who provides them? What are the coverage gaps? Who is not being reached?	Service mapping; health system assessments; coverage surveys; stakeholder consultations
Resource mapping	What human, financial, and material resources are available? What are the gaps?	Facility inventories; staff records; budget analysis; donor mapping
Stakeholder analysis	Who are the key actors — government, community, donors, NGOs? What are their interests, power, and positions?	Stakeholder mapping workshops; literature review; interviews

B. Problem Tree Analysis

The Problem Tree is a visual tool for organizing the causes and effects of a health problem in a systematic, hierarchical structure. It ensures that Program design addresses root causes, not just symptoms:

Problem Tree Level	What It Shows	Example: High Child Malnutrition
Effects (above the trunk)	The consequences of the core problem — what happens if it is not addressed. These become the Program's development objectives	High child mortality; reduced school performance; low adult productivity; high healthcare costs; intergenerational poverty
Core Problem (the trunk)	The central problem the Program will address — specific and clearly defined	High prevalence of acute malnutrition (wasting) among children under 5 in the target district
Direct causes (main roots)	The immediate causes that directly produce the core problem	Inadequate dietary intake; high burden of infectious disease; poor infant and young child feeding practices
Underlying causes (deeper roots)	The underlying factors that produce the direct causes — addressable by the Program	Household food insecurity; limited access to health services; low maternal education; poor WASH conditions
Root causes (deepest roots)	The structural causes — often beyond the Program's direct control but important to acknowledge	Poverty; gender inequality; conflict and displacement; inadequate government investment in health and nutrition

Key Point: *The Problem Tree is then converted into an Objective Tree by restating each problem as a positive achievement (e.g., 'High child malnutrition' becomes 'Reduced child malnutrition'). The Objective Tree becomes the basis for the Program's Theory of Change.*

C. SWOT Analysis

SWOT Analysis (Strengths, Weaknesses, Opportunities, Threats) provides a structured assessment of the internal and external factors affecting Program design and implementation:

SWOT Element	Definition	Health Program Example
Strengths (Internal, positive)	Existing capabilities, resources, and advantages the Program can build on	Experienced Program staff; established community health worker network; strong relationship with Ministry of Health; existing supply chain infrastructure
Weaknesses (Internal, negative)	Internal limitations, gaps, or disadvantages that must be addressed	Limited M&E capacity; high staff turnover; weak cold chain in remote areas; insufficient budget for supervision
Opportunities (External, positive)	External conditions or events that the Program can leverage	New government nutrition policy provides mandate; donor interest in this area is high; new mobile health technology available; community leader support secured
Threats (External, negative)	External risks or challenges that could undermine the Program	Conflict and insecurity in target areas; high inflation affecting procurement; competing donor priorities; staff recruitment competition from private sector

III. THEORY OF CHANGE

A. What Is a Theory of Change?

A Theory of Change (ToC) is an explicit description of how and why a set of activities is expected to produce desired outcomes and impact. It maps the causal pathway from inputs and activities through to long-term change, making the Program's underlying assumptions visible and testable. A ToC answers: 'If we do X, then Y will happen, because Z.'

1	INPUTS — What resources do we invest? Financial resources (budget); human resources (staff, volunteers); physical resources (equipment, supplies); information resources (data, guidelines). These are what the Program brings to the work.
▼	
2	ACTIVITIES — What do we do with the inputs? The specific actions and interventions the Program implements: training sessions, outreach visits, distribution of supplies, awareness campaigns, supervision visits, policy advocacy.
▼	
3	OUTPUTS — What is directly produced by our activities? The tangible, immediate products of activities: number of health workers trained; number of households reached; kg of therapeutic food distributed; number of supervision visits conducted. Outputs are within the Program's direct control.
▼	
4	OUTCOMES — What changes as a result of our outputs? (SHORT-TERM) Changes in knowledge, attitudes, behaviour, or service utilization among target beneficiaries: improved feeding practices; increased service utilization; better nutritional knowledge among caregivers. Outcomes require beneficiary response — not fully within Program control.
▼	

5	OUTCOMES — What changes as a result? (MEDIUM-TERM) Intermediate changes in conditions: improved nutritional status of children; reduced incidence of preventable disease; increased coverage of essential services. Influenced by the Program but also by many other factors.
▼	
6	IMPACT — What is the long-term change in population wellbeing? The ultimate goal: reduced child mortality; improved population nutritional status; better health equity. Impact takes years to achieve and is influenced by many factors beyond the Program.

Figure: Theory of Change — the causal chain from inputs to impact

The ToC must also explicitly state the KEY ASSUMPTIONS — the conditions that must hold true for each causal link to work. Assumptions are the most important and most often neglected element of Program design:

- Assumption example 1 (between Activities and Outputs): 'Trained health workers will apply new skills in practice' — this requires adequate supervision and functional supply chains
- Assumption example 2 (between Outputs and Outcomes): 'Caregivers who receive nutrition counselling will change their feeding practices' — this requires that recommended foods are available and affordable
- Assumption example 3 (between Outcomes and Impact): 'Improved feeding practices will be sustained beyond the Program period' — this requires community ownership and behaviour change

Remember: *Every broken assumption is a Program failure waiting to happen. Rigorous ToC development identifies the most critical assumptions — and the Program design includes specific activities to test and support them.*

IV. THE LOGICAL FRAMEWORK (LOGFRAME)

A. Structure of the LogFrame Matrix

The Logical Framework (LogFrame) is the standard planning and accountability tool used by virtually all major health Program donors and implementing organizations. It converts the Theory of Change into a structured matrix of goals, indicators, means of verification, and assumptions:

LogFrame Level	Description	Indicator Example	Means of Verification	Assumptions
GOAL (Impact)	The long-term development objective the Program contributes to — shared with other Programs	% of children under 5 who are wasted (WHZ<-2SD) in target area decreases from 14% to 8% by Year 5	Population-representative SMART nutrition survey at baseline and Year 5	Broader food security conditions do not deteriorate; no major conflict disruption
PURPOSE (Outcome)	The specific result the Program is designed to achieve — the primary accountability level	% of children 6-59 months in target communities receiving minimum acceptable diet increases from 25% to 60% by Year 3	Household survey at baseline, midterm (Year 2), and endline (Year 3)	Caregivers have time and resources to prepare recommended foods; recommended

				foods are available in local markets
OUTPUTS	The tangible products delivered by the Program — directly within management control	1. 500 community health workers trained in IYCF counselling by Month 6; 2. 20,000 households reached with nutrition counselling by Year 2; 3. 95% of OTP sites with uninterrupted RUTF supply	Training attendance registers; household visit records; supply chain tracking system	Staff recruited and trained on schedule; RUTF procurement not delayed; community acceptance of CHW visits
ACTIVITIES	The specific tasks carried out to produce the outputs	1.1 Recruit and train CHWs; 1.2 Develop counselling materials; 1.3 Establish supervision system; 2.1 Conduct household visits; 2.2 Run cooking demonstrations; 3.1 Establish reorder system	Work plan tracking; monthly activity reports; financial reports	Funding disbursed on schedule; government co-operation maintained; no force majeure events

Key Point: *The LogFrame is a living document — it should be reviewed and updated regularly as the Program learns. A LogFrame that was written at Program design and never revisited is a planning artefact, not a management tool.*

V. WORK PLANNING

A. From LogFrame to Operational Work Plan

The work plan operationalizes the LogFrame — converting the activities column into a time-sequenced action plan with assigned responsibilities, milestones, and resource requirements. A good work plan answers: Who does what, by when, with what resources, and how will we know it is done?

Activity / Task	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Responsible
1. Situation Analysis									Program Manager
2. Stakeholder Mapping									Prog. Manager + Team
3. ToC & LogFrame Development									Technical Officer
4. Work Plan Finalisation									All team members
5. Budget Development									Finance Officer
6. Risk Register									Program Manager
7. Partner Consultation									Program Manager
8. Plan Approval & Launch									Director + All

Figure: Illustrative work plan / Gantt chart for a health Program design phase (8 weeks)

Work Plan Element	Description	Practical Guidance
Activities	The specific tasks to be completed — derived from the LogFrame activities column	Break each LogFrame activity into concrete, manageable sub-tasks. Each task should be compellable in 1-4 weeks
Timeline / Gantt	Visual representation of when each activity occurs and its duration	Use a Gantt chart to show activity sequencing; identify critical path activities (those where delays affect all subsequent work)
Responsible party	The person or team accountable for completing each activity	Assign one named person as accountable — not 'the team'. Accountability diffused across groups means no one is accountable
Milestones	Key achievement points that mark progress — measurable and time-bound	'Training materials finalized by Week 3'; '500 CHWs trained by Month 4'; 'First monitoring report submitted by Month 5'
Resources required	What inputs are needed for each activity: budget, staff time, materials, equipment	Link activities to budget lines so resource needs and costs are explicitly connected to the work plan

VI. RISK MANAGEMENT IN PROGRAM DESIGN

Every Program operates in an uncertain environment. Risk management involves identifying potential threats to Program success, assessing their likelihood and impact, and designing mitigation strategies before they materialize:

Risk	Likelihood (H/M/L)	Impact (H/M/L)	Risk Level	Mitigation Strategy	Contingency Plan
Conflict escalation disrupts field operations	H	H	CRITICAL	Conflict-sensitive Program design; access protocols; security training for staff	Shift to remote monitoring; suspend field operations; activate emergency response protocols
RUTF stockout due to procurement delay	M	H	HIGH	Maintain 3-month buffer stock; dual supplier arrangement; pre-positioned stock at state level	Emergency procurement from alternate supplier; BSFP as bridge response
Key staff turnover	M	M	MEDIUM	Competitive salary; professional development; succession planning; documentation of institutional knowledge	Cross-training of staff; recruitment plan activated within 2 weeks of departure
Community resistance to Program	L	H	MEDIUM	Early community engagement; involve community leaders in design; culturally	Community dialogue sessions; adapt approach based

				appropriate messaging	on specific concerns; involve trusted intermediaries
Currency inflation increases procurement costs	M	M	MEDIUM	Budget contingency reserve (10%); flexible budget lines; regular financial monitoring	Request budget revision from donor; reprioritize activities; seek supplementary funding

Remember: *Risk management is not about eliminating risk — it is about making risks visible, assigned, and managed. A Program that does not identify risks has not eliminated them; it has simply chosen to be surprised by them.*

Practical Tool: LogFrame Design Exercise

- You are designing a 3-year community-based maternal and newborn health Program in a peri-urban area of Khartoum. The situation analysis shows: maternal mortality ratio of 350/100,000 live births; only 45% of births attended by skilled personnel; high rate of newborn infections due to poor hygiene practices at delivery; low antenatal care attendance (3+ visits: 30%).
- Using the LogFrame template, complete the following:
- 1. Write ONE Goal-level statement and ONE appropriate impact indicator with a realistic target
- 2. Write TWO Purpose-level outcomes and ONE indicator for each
- 3. Write FOUR Outputs that would plausibly produce your stated outcomes
- 4. For each Output, write ONE measurable indicator and identify the data source (means of verification)
- 5. List THREE critical assumptions for your Program's Theory of Change
- 6. Identify TWO major risks and propose a mitigation strategy for each

Case Study: Designing a Child Nutrition Program — From Problem Tree to LogFrame

- Context: A district in North Darfur has a GAM rate of 18.5% (above emergency threshold of 15%) and SAM rate of 4.2%. The needs assessment found: 70% of households are food insecure; only 15% of children with SAM are reached by treatment; ANC attendance is low; community health worker network is inactive due to lack of incentives; cold chain for RUTF is functional at district but not facility level.
- Problem Tree summary: Core problem = High rates of acute malnutrition. Direct causes = Inadequate dietary intake + high infection burden + poor IYCF practices. Underlying causes = Household food insecurity + inadequate CMAM coverage + inactive CHW network. Root causes = Poverty + conflict + under-resourced health system.
- Design challenge: The Program has a 2-year budget of USD 800,000 and must work within existing government systems.
- Question 1: Draw the ToC for this Program — map the causal chain from your planned inputs to the intended impact, and identify 3 critical assumptions.
- Question 2: Convert your ToC into a 4-row LogFrame matrix. Write SMART indicators for the Goal and Purpose levels.

• Question 3: The Program manager proposes to focus only on CMAM (SAM treatment) since 'that is the most evidence-based intervention.' Using the problem tree and ToC, argue for or against this approach.

Reflection / Discussion Questions

• Why do you think Program design is described as 'the most important and most neglected phase of Program management'? What organizational pressures encourage under-investment in design?

• What is the difference between outputs and outcomes in a health Program? Why does this distinction matter for accountability and evaluation?

• A donor requires a LogFrame with 15 output indicators and 8 outcome indicators. A Program manager argues this will create data overload and reduce M&E quality. Who is right? What is the ideal number of indicators for a well-designed Program?

Session Summary — Key Takeaways

• Program design is the foundation of Program success — it defines what the Program will do, how it will create change, and how success will be measured. Poor design is the most common cause of Program failure, not poor implementation

• Situation analysis tools: Needs assessment (epidemiological, causal, service gap, resource, stakeholder); Problem Tree (causes and effects organized hierarchically); SWOT Analysis (internal strengths/weaknesses; external opportunities/threats). These ensure design addresses root causes, not just symptoms

• Theory of Change maps the causal chain: Inputs → Activities → Outputs → Short-term Outcomes → Medium-term Outcomes → Impact. Critical assumptions must be explicitly stated at each link — they are the most important and most neglected element of Program design

• The LogFrame matrix (Goal/Purpose/Outputs/Activities × Description/Indicators/MoV/Assumptions) is the universal standard for health Program planning. Indicators must be SMART; means of verification must be realistic; assumptions must be actively managed

• Work plans operationalize the LogFrame: Gantt chart sequencing; named accountability for each task; milestones; resource linkage. The critical path identifies activities where delays cascade to all subsequent work

• Risk management: identify, assess (likelihood × impact), priorities (critical/high/medium/low), mitigate, and plan contingencies. Risk management makes uncertainty visible and managed — not eliminated

Suggested Reading:

1. Imas LGM & Rist RC (2009). The Road to Results — Chapter 4: Logic Models. World Bank. |
2. Vogel I (2012). Review of the Use of 'Theory of Change' in International Development. DFID. |
3. USAID (2013). Designing for Monitoring, Evaluation and Learning. |
4. Practical Concepts Inc. (1979). The Logical Framework Approach. |
5. MSH (2008). Managers Who Lead — Chapter 5.

Management & Leadership of Health Programs | BSc Public Health

Session 5

Strategic Planning

From Mission to Action: Vision, SWOT, Strategic Goals & Balanced Scorecard

Ahfad University for Women | Topic Two: Management Functions

Learning Outcomes
• Define strategic planning and explain its importance for health Program management • Describe the components of a strategic plan: mission, vision, values, situational analysis, strategic goals, and implementation plan
• Apply SWOT and PESTLE analysis to assess the internal and external environment of a health organization • Distinguish between strategic planning and operational planning — and understand how they connect
• Describe the Balanced Scorecard as a strategic management and performance measurement tool • Apply strategic planning concepts to develop strategic goals and objectives for a health organization

I. WHAT IS STRATEGIC PLANNING?

A. Definition and Purpose

Strategic planning is the management process by which an organization determines its long-term direction, sets priorities, and allocates resources to pursue those priorities. It answers three fundamental questions: Where are we now? Where do we want to be? How do we get there?

Strategic planning is distinct from operational planning (which focuses on the 'how' of day-to-day delivery) and from Program design (which focuses on a specific intervention). Strategic planning operates at the organizational level, defining the overall direction, mission, and long-term goals that give all Programs and operations their purpose and coherence.

Planning Level	Time Horizon	Focus	Outputs	Who is Responsible
Strategic Planning	3–10 years	Organizational direction, mission, long-term goals, resource priorities	Strategic plan; vision statement; strategic goals and objectives	Board, top management, senior leadership
Operational Planning	1–2 years	How to implement strategy; annual priorities; departmental plans	Annual operational plan; departmental work plans; annual budget	Middle management, department heads
Program/Project Design	Program duration	Specific intervention logic, ToC, LogFrame, work plan	Program design document; LogFrame; budget	Program managers, technical staff

Key Point: *Strategic planning without operational follow-through is fantasy. Operational planning without strategic direction is purposeless activity. The linkage between the strategic plan and the operational plan — and from there to each Program — is the most important and most often broken connection in health organizations.*

II. THE STRATEGIC PLANNING PROCESS

Strategic planning follows a structured process. While the specific steps may vary by organization and methodology, the core elements are consistent:

1. Clarify Mission & Values
2. Situational Analysis
3. Identify Strategic Issues
4. Set Strategic Goals & Objectives
5. Develop Strategies
6. Implementation Plan & Budget
7. Monitor & Review

Figure: The strategic planning process — seven interconnected steps

III. MISSION, VISION, AND VALUES

A. The Three Foundations of Strategic Direction

Every strategic plan begins with a clear articulation of why the organization exists, what it aspires to become, and how it will conduct itself. These three statements, mission, vision, and values — are not mere words on a wall; they are the strategic compass that guides all decisions:

Foundation	Definition	Key Questions it Answers	Health Organization Example
MISSION (Purpose — the WHY)	A concise statement of the organization's fundamental purpose — why it exists and who it serves. Present tense; action-oriented; specific enough to guide decisions	Why do we exist? What do we do? For whom? What value do we create?	'To improve the health and wellbeing of women and children in Sudan through accessible, high-quality community health services and evidence-based advocacy'
VISION (Aspiration — the WHAT)	An inspiring picture of the desired future state — what the organization aspires to achieve or create over the long term. Future tense; ambitious but achievable; motivating	What do we want to create? What does success look like in 10 years? What future are we building toward?	'A Sudan where every woman and child has access to the health services they need to survive, thrive, and reach their full potential'
VALUES (Principles — the HOW)	The core beliefs and ethical principles that guide how the organization conducts its work — its non-negotiable commitments	How do we work? What principles guide our decisions? What do we refuse to compromise?	Excellence in service delivery; integrity in all relationships; equity — prioritizing the most vulnerable; community ownership; evidence-based practice

Remember: *A mission statement that tries to be all things to all people says nothing. The best mission statements are specific enough to explain what the organization does NOT do. If your mission could equally describe any health organization in the world, it needs more work.*

IV. SITUATIONAL ANALYSIS — SCANNING THE ENVIRONMENT

A. SWOT Analysis (Revisited for Strategic Level)

At the strategic level, SWOT analysis examines the organization as a whole — not just a single Program. It asks: What are our organizational strengths and weaknesses? What opportunities and threats exist in our external environment?

	INTERNAL (Organization)	EXTERNAL (Environment)
HELPFUL (to achieving objectives)	**STRENGTHS (Internal +)** • Strong technical expertise in target health areas • Well-established community trust and relationships • Diverse funding base reduces dependency • Experienced leadership team • Robust M&E systems and data culture	**OPPORTUNITIES (External +)** • New government health strategy creates policy alignment • Increasing donor interest in community health • New mobile health technologies available • Post-conflict reconstruction funding streams • Regional networks for knowledge sharing
HARMFUL (to achieving objectives)	**WEAKNESSES (Internal −)** • High staff turnover in technical positions • Weak financial management systems • Geographic concentration — limited reach • Under-investment in staff development • Poor documentation of institutional knowledge	**THREATS (External −)** • Deteriorating security situation in target areas • Currency instability affecting procurement • Competition for skilled staff from private sector • Donor priorities shifting away from core mandate • Regulatory environment increasingly restrictive for NGOs

Figure: SWOT Analysis — organizational strategic assessment tool

B. PESTLE Analysis — Scanning the Macro-Environment

PESTLE analysis examines the macro-environmental factors beyond the organization's control that create opportunities and threats for its strategic position:

PESTLE Factor	Description	Questions to Ask	Sudan Health Context Example
Political	Government policies, political stability, health sector priorities, regulatory environment	What health policies are being enacted? Is the government supportive of our mandate? What political risks exist?	Transitional governance creates both opportunity (reform window) and risk (instability); SUN membership signals nutrition priority; military spending crowds out health budget
Economic	Macroeconomic conditions, funding landscape, inflation, exchange rates, household income	Is donor funding increasing or decreasing? How does inflation affect our budget? What economic shocks might affect our target population?	Hyperinflation erodes real budget value; currency devaluation increases import costs; household poverty worsening — increasing service need while reducing government resources

Social	Demographic trends, cultural factors, community attitudes, gender norms, education levels	What social changes are affecting health behaviour? How do gender norms affect service utilization? What is the literacy level of target communities?	Young, growing population; high disease burden; gender inequality limits women's health-seeking; strong community and tribal social structures — both barriers and entry points
Technological	New health technologies, digital health, communication technologies, supply chain innovations	What new technologies could improve service delivery or M&E? Are communities accessing digital information?	Mobile phone penetration growing even in rural areas; mobile health potential; solar-powered cold chain improving reach; telemedicine potential for specialist consultations
Legal	Regulatory framework, NGO registration requirements, labour law, intellectual property	What legal requirements affect our operations? Are there new laws affecting our mandate?	NGO law amendments may restrict international funding; labour law changes affecting staff contracts; new pharmaceutical regulations affecting supply chain
Environmental	Climate, geography, natural disasters, food security, environmental health	How does climate change affect our target population's health? What environmental factors determine disease burden?	Increasing drought frequency worsening food insecurity; flooding expanding malaria range; desertification driving displacement and nutritional vulnerability

V. STRATEGIC GOALS, OBJECTIVES, AND STRATEGIES

A. The Hierarchy from Mission to Action

The strategic plan translates the mission and vision into actionable goals, objectives, and strategies. Each level of this hierarchy must be coherent and directly linked to the level above:

MISSION & VISION — Why we exist and what we aspire to create
STRATEGIC GOALS — The 3-5 major areas where we will achieve change over the next 3-5 years
STRATEGIC OBJECTIVES — Specific, measurable results we will achieve within each goal (SMART)
STRATEGIES — How we will achieve each objective: the approaches and major initiatives
OPERATIONAL PLANS — Annual plans, work plans, budgets — the day-to-day how

Figure: From mission to operational action — the strategic hierarchy

Example: *Goal: 'Improve maternal and newborn health outcomes in target communities.' Objective: 'Increase the proportion of skilled birth attendance from 45% to 70% in target districts by 2027.' Strategy: 'Strengthen community midwifery; establish referral systems; engage traditional birth attendants as referral agents; address financial barriers through voucher scheme.'*

Level	Characteristics	Quality Test
Strategic Goal	Broad, 3-5 year achievement; aligns with mission; typically 3-5 goals per strategic plan	Does achieving this goal take us significantly closer to our vision? Is it within our sphere of influence?
Strategic Objective	SMART: Specific, Measurable, Achievable, Relevant, Time-bound; quantified target; attributable to the organization's work	Can we measure this? Is the target ambitious but realistic? Does it directly serve the strategic goal?
Strategy	Describes the major approach or initiative — not the individual activities; addresses the key barriers	Does this strategy address the most critical constraints to achieving the objective? Is it feasible given our resources?
Operational Plan	Annual; detailed; specific tasks with timelines, responsibilities, and budgets	Does every planned activity serve an identified strategy? Is there a clear budget and accountability structure?

VI. THE BALANCED SCORECARD

A. Beyond Financial Measurement

The Balanced Scorecard (Kaplan & Norton, 1992) is a strategic management and performance measurement framework that goes beyond financial indicators to provide a 'balanced' view of organizational performance across four interconnected perspectives. It is widely used in health organizations to translate strategy into measurable performance goals:

BSC Perspective	Central Question	Health Organization Indicators	Strategic Link
Financial / Stewardship (Are we being good stewards of resources?)	How should we manage our resources to satisfy our funders and demonstrate value?	Budget utilization rate; cost per beneficiary reached; % of overhead vs. Program spend; audit findings; donor retention rate	Ensures organizational sustainability and accountability to funders
Stakeholder / Beneficiary (Are we creating value for those we serve?)	How do our beneficiaries and key stakeholders view us? Are we delivering on our mission?	Beneficiary satisfaction score; % of target population reached; service quality ratings; community trust index; government relationship quality	Keeps the organization focused on its primary purpose — serving communities
Internal Processes (Are we operating efficiently and effectively?)	Which internal processes must we excel at to serve our beneficiaries and manage our resources?	Program delivery timeliness; supply chain reliability; supervision visit completion rate; data quality score; staff productivity indicators	Identifies the operational excellence required to deliver the mission
Learning & Growth (Can we continue to improve and innovate?)	How will we sustain our ability to change, improve, and grow?	Staff training hours per year; staff satisfaction and retention rate; new partnerships established; research and learning outputs; innovation adoption rate	Ensures long-term organizational capacity and adaptability

Key Point: *The power of the Balanced Scorecard is that it shows how the four perspectives are causally linked: Investment in learning and growth (perspective 4) improves internal processes (3), which improves beneficiary outcomes (2), which demonstrates stewardship (1), which attracts resources for further learning and growth. Strategy is the story of how these connections work.*

VII. STRATEGIC PLANNING IN RESOURCE-LIMITED HEALTH SETTINGS

Strategic planning in low-resource settings like Sudan faces specific challenges that require adaptation of standard frameworks:

- Compressed planning cycles: In conflict-affected or rapidly changing environments, 5-year strategic plans may be unrealistic. Rolling 2-3 year plans with annual review are more appropriate
- Participatory process: In resource-limited settings, community participation in strategic planning is both ethically important and practically valuable, communities have knowledge of local realities that external planners lack
- Donor alignment tension: Organizations dependent on donor funding face pressure to align strategic priorities with donor preferences rather than community needs. A strong strategic plan provides the backbone for negotiating with donors rather than simply following their priorities
- Scenario planning: In high-uncertainty environments (conflict, political instability, climate shocks), strategic plans should include multiple scenarios and pre-define how the organization will respond to different futures
- Living documents: Strategic plans must be treated as living documents reviewed quarterly — not filed and forgotten. Regular review against the external environment is essential for organizational relevance

Practical Tool: Strategic Planning Workshop Activity

- Working in groups of 4-5, you are the strategic planning team for a hypothetical district-level NGO called 'Sahel Health Initiative' operating in North Darfur, Sudan. The organization provides maternal and child health services across 12 health facilities.
- Step 1 — Mission & Vision (10 min): Draft a one-sentence mission statement and a one-sentence vision statement for Sahel Health Initiative. Ensure the mission is specific enough to guide what the organization will and will not do.
- Step 2 — SWOT Analysis (15 min): Complete a SWOT analysis for this organization in the current North Darfur context. Each quadrant should have at least 4 items. Identify the 2 most important items in each quadrant.
- Step 3 — Strategic Issues (10 min): Based on your SWOT, identify the 3 most critical strategic issues facing Sahel Health Initiative over the next 3 years.
- Step 4 — Strategic Goals (10 min): Write 3 strategic goals that address your identified strategic issues and align with your mission.
- Step 5 — SMART Objectives (15 min): For ONE of your strategic goals, write 2 SMART objectives. For each objective, identify 2 strategies (approaches) you will use to achieve it.
- Step 6 — Balanced Scorecard (10 min): For the same strategic goal, develop 1 indicator for each of the 4 BSC perspectives.
- Group presentations: Each group presents their strategic framework (5 minutes per group). Class provides constructive feedback on specificity, realism, and strategic coherence.

Case Study: Strategic Planning at Ahfad University Health Program — A Learning Case

- Context: A university-based community health Program has been operating for 8 years with strong donor support. It has developed excellent technical expertise in maternal health and nutrition. However: donor priorities are shifting; the government is pushing for integration of vertical Programs into the health system; a new regional competitor has entered the area; and staff morale is low due to uncertainty about the future.
- Current situation: The Program has no formal strategic plan — it has grown reactively in response to donor opportunities rather than according to a coherent strategic vision. Each project is well-designed, but there is no clear organizational direction linking them.
- PESTLE triggers: Political (government integration push); Economic (donor shift away); Social (growing community expectations); Technological (mobile health emerging); Legal (new NGO regulations); Environmental (worsening food security affecting health indicators).
- Question 1: The Program director argues that 'strategic planning is a luxury — we need to focus on delivery, not planning.' Do you agree? How would you make the case for investing in strategic planning at this moment?
- Question 2: Given the PESTLE triggers, identify 2 strategic opportunities and 2 strategic threats that should shape the new strategic plan.
- Question 3: Draft ONE strategic goal for this organization that responds to the most critical strategic issue. Write 2 SMART objectives for it. Identify which BSC perspective each objective primarily addresses.

Reflection / Discussion Questions

- What is the difference between a strategic goal and a strategic objective? Write an example of each for a maternal health Program — and explain how you know your objective is truly SMART.
- An organization has a beautiful mission statement, a compelling vision, and a well-written strategic plan — but the plan is never referred to in day-to-day management decisions. What has gone wrong? What would you do to fix it?
- How does the Balanced Scorecard challenge the traditional tendency of health organizations to focus only on health output and outcome indicators? Why is the learning and growth perspective especially important for organizations working in fragile settings like Sudan?

Session Summary — Key Takeaways

- Strategic planning answers: Where are we now? Where do we want to be? How do we get there? It operates at the organizational level with a 3-10 year horizon — above operational planning and Program design, providing the direction that gives all activities purpose
- Mission (why we exist), Vision (what we aspire to create), and Values (how we work) are the three foundations of strategic direction. They must be specific, meaningful, and actively used — not just printed on office walls
- SWOT analysis: Strengths and Weaknesses (internal); Opportunities and Threats (external). PESTLE analysis: Political, Economic, Social, Technological, Legal, Environmental macro-factors. Both tools illuminate the strategic situation and inform goal-setting

• Strategic hierarchy: Mission/Vision → Strategic Goals (3-5 year) → Strategic Objectives (SMART) → Strategies (major approaches) → Operational Plans (annual, detailed). Every level must be coherently linked to the level above

• Balanced Scorecard (Kaplan & Norton): four perspectives — Financial/Stewardship; Stakeholder/Beneficiary; Internal Processes; Learning & Growth. Provides a balanced, causally connected view of performance beyond financial/output measurement alone

• Strategic planning in resource-limited settings: use compressed planning cycles (2-3 years); ensure community participation; maintain strategic independence from donor preferences; plan for multiple scenarios; treat the plan as a living document reviewed quarterly — not an annual filing exercise

Suggested Reading:

1. Kaplan RS & Norton DP (1992). The Balanced Scorecard. Harvard Business Review. |
2. Bryson JM (2018). Strategic Planning for Public and Nonprofit Organizations. 5th Ed. |
3. WHO (2012). Health Systems Strengthening — Strategic Planning. |
4. MSH (2008). Managers Who Lead — Chapter 6: Strategic Planning.

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Session 6

Time Management

Principles, Tools & Strategies for Managing Your Most Valuable Resource

Ahfad University for Women | Topic Two: Management Functions

Learning Outcomes

- Explain why time management is a critical managerial competency in health Program settings
- Apply the Eisenhower Matrix to priorities tasks by urgency and importance
- Identify common time thieves in health management and develop strategies to address them
- Use practical time management tools: daily planning, delegation, meeting management, and the 80/20 rule
- Develop a personal time management plan appropriate for a health Program manager
- Recognize the relationship between poor time management, manager stress, and team performance

I. WHY TIME MANAGEMENT MATTERS

A. Time as the Manager's Scarcest Resource

Time is the one resource that cannot be stored, borrowed, recycled, or recovered. A manager who wastes money can raise more; a manager who wastes time has lost it permanently. In health Programs, poor time management cascades directly into poor Program performance: supervision visits are skipped, reports are submitted late, staff development is neglected, and strategic thinking is crowded out by reactive firefighting.

Research consistently shows that managers who feel they 'have no time' are often spending large proportions of their working day on low-value activities that could be delegated, eliminated, or batched — while systematically neglecting the high-value activities (strategic planning, supervision, staff development, community engagement) that produce the greatest Program impact.

The Time Management Paradox	Description
Busyness ≠ Productivity	A manager who is constantly busy, always rushed, and always in meetings may be producing very little of strategic value. Activity and productivity are not the same thing.
Urgency bias	Humans naturally attend to urgent tasks — they demand immediate attention. But urgent tasks are not always important. The most important managerial activities (planning, prevention, development) are rarely urgent — and therefore consistently neglected.
The planning paradox	Managers who say they have no time to plan are the managers who most need to plan. Ten minutes of daily planning saves an hour of reactive correction. An hour of weekly planning saves a day of confusion. A day of annual planning saves weeks of misalignment.
Delegation failure	Many managers fail to delegate because they believe it is faster to do tasks themselves. This is true in the short term and catastrophically false in the long term — it creates a bottleneck, stunts staff development, and guarantees the manager is always overloaded.

Key Point: *Effective time management is not about doing more things faster. It is about doing fewer things better — the right things, at the right time, to the right standard — and delegating or eliminating the rest.*

II. THE EISENHOWER MATRIX — PRIORITISING BY URGENCY AND IMPORTANCE

Attributed to President Dwight D. Eisenhower and popularized by Stephen Covey in 'The 7 Habits of Highly Effective People', the Eisenhower Matrix provides a simple but powerful framework for categorising tasks by two dimensions: urgency (does it require immediate attention?) and importance (does it contribute to long-term goals and mission?):

	URGENT	NOT URGENT
IMPORTANT	**QUADRANT 1: DO FIRST** *Important & Urgent* Crisis management; deadlines; emergencies Health example: Disease outbreak response; patient emergency; missed report deadline	**QUADRANT 2: SCHEDULE** *Important & Not Urgent* Strategic planning; staff development; relationship building; prevention activities Health example: Supervision planning; staff training; community engagement; protocol development
NOT IMPORTANT	**QUADRANT 3: DELEGATE** *Not Important & Urgent* Interruptions; some meetings; some emails; requests from others Health example: Routine administrative requests; non-critical meetings; routine supply queries	**QUADRANT 4: ELIMINATE** *Not Important & Not Urgent* Time wasters; trivial tasks; excessive social media; unnecessary meetings Health example: Preparing reports no one reads; attending meetings with no relevant agenda

Figure: The Eisenhower Matrix — Urgency vs. Importance for time management decisions

The most important insight of the Eisenhower Matrix is the danger of Quadrant 1 dominance. Managers who spend most of their time in Q1 (important and urgent crises) are usually there because they neglected Q2 (important, not urgent) activities like planning, prevention, and staff development. The solution is not to manage crises better, it is to invest more time in Q2 to prevent crises from developing.

Quadrant	Strategy	Health Management Example	Warning Sign of Over-Spending Time Here
Q1: Important & Urgent (DO FIRST)	Handle immediately; develop prevention systems to reduce future Q1 volume	Outbreak response; missed donor deadline; equipment failure affecting patient care	Constant firefighting; reactive management; stress and burnout; no time for planning
Q2: Important & Not Urgent (SCHEDULE)	Block time proactively — this quadrant will never naturally feel urgent enough	Supervision system design; staff training plan; community needs assessment; strategic review	Consistently under-resourced; activities always postponed; Programs become reactive
Q3: Not Important & Urgent (DELEGATE)	Delegate to appropriate staff; set boundaries; question if meetings/requests are necessary	Routine administrative approvals; non-critical supply requests; low-priority meetings	Manager becomes bottleneck; staff under-utilized; manager's time consumed by others' work

Q4: Not Important & Not Urgent (ELIMINATE)	Eliminate entirely; Recognize and stop time-wasting habits	Unnecessary report preparation; redundant internal emails; low-value meetings; excessive social media	Energy drain; professional guilt; crowding out valuable activities with busyness

Remember: *Most health managers should aim for: Q1 = 20-25% of time; Q2 = 60-70% of time; Q3 = 10-15% of time; Q4 = 0-5% of time. If Q1 >50% of your week, you have a prevention and planning deficit — not a time deficit.*

III. COMMON TIME THIEVES IN HEALTH MANAGEMENT

Time thieves are activities, habits, and organizational patterns that consume management time without producing proportionate value. Identifying your personal time thieves is the first step to reclaiming productive time:

Time Thief	Description	Typical Impact	Management Strategy
Unplanned interruptions	Unscheduled visits, phone calls, and requests that break concentration and derail planned work	A manager interrupted every 15 minutes cannot sustain complex thinking. Research shows it takes 23 minutes to fully regain concentration after an interruption	Designate 'protected time' for deep work (2-hour blocks with no interruptions); use scheduled office hours for routine queries; train staff to batch non-urgent requests
Poorly managed meetings	Meetings that start late, have no agenda, run over time, produce no decisions, and require no follow-up	A 1-hour meeting with 8 people costs 8 staff-hours, equivalent to a full workday. Most organizations waste 25-50% of meeting time	Apply the meeting discipline rules: agenda sent 24 hours before; start on time; end on time; document decisions and actions; question if meeting is necessary at all
Unclear priorities	When everything is urgent and important, nothing is. Without clear priorities, managers respond to whoever shouts loudest	Staff bring problems to the manager that they should resolve themselves; manager makes reactive decisions without strategic coherence	Use the Eisenhower Matrix weekly; communicate clear Program priorities to all staff; empower staff to make Q3 decisions without escalation
Perfectionism	Spending excessive time refining work to a higher standard than the situation requires	A report that needs to be 'good enough' to support a decision receives 6 hours of polishing instead of 2	Apply the 80% rule: most professional outputs should be produced to 80% quality in 20% of the time it would take to perfect them. Perfect is the enemy of done.
Inability to say no	Accepting every request, invitation, and task offered — even those that do not align with core responsibilities	A manager who cannot decline non-priority requests has surrendered control of her time to others' priorities	Develop a polite but firm 'no' for off-mandate requests; use 'not now' rather than 'never'; protect time by being selective about commitments

Email and digital communication	Checking email/WhatsApp constantly; treating every message as requiring immediate response	Context-switching between communication and work reduces productivity by up to 40%. Constant notification checking creates the illusion of responsiveness	Batch email checking to 2-3 specific times per day; disable notifications during deep work; use subject lines and flags to priorities; set response time expectations
Procrastination	Delaying difficult, complex, or unpleasant tasks — often by doing easier, more comfortable tasks instead	Critical tasks are postponed while low-value activity expands to fill the time; deadlines become crises	Apply the 'eat the frog' principle: tackle the most difficult task first thing in the morning when cognitive energy is highest. Break large tasks into smaller, manageable steps.

IV. PRACTICAL TIME MANAGEMENT TOOLS

A. Daily and Weekly Planning

The most powerful time management habit is consistent daily and weekly planning. Most high-performing managers spend 10-15 minutes at the end of each day planning the next day, and 30-60 minutes at the end of each week planning the next week:

- Daily planning (10 minutes, end of each day): List 3 'Must Complete' tasks for tomorrow; 3 'Should Complete' tasks; identify your most important single task (MIT, Most Important Task) and schedule it for your peak energy time
- Weekly planning (30 minutes, end of each week): Review the week just completed, what was achieved, what was not, and why; review the coming week's calendar and commitments; identify Q2 activities that need protected time; review progress against work plan milestones
- The 'time audit': For one week, record how you actually spend your time in 30-minute blocks. Compare to how you think you spend your time. The gap is almost always revealing, and often shocking

B. The Pareto Principle (80/20 Rule)

The Pareto Principle, originally observed by Italian economist Vilfredo Pareto (1906) and applied to management by Joseph Juran, states that in most systems, 80% of outcomes are produced by 20% of causes. Applied to time management:

Figure: The 80/20 Rule: 20% of your activities produce 80% of your Program results — identify and protect that 20%

- The managerial implication: Identify the 20% of your activities that produce 80% of your Program value — and protect that time ruthlessly. For a health Program manager, this might be: quality supervision visits; strategic stakeholder meetings; performance data review; staff coaching sessions
- Identify the 80% that produces only 20% of value and systematically reduce, delegate, or eliminate those activities
- Health application: If a manager conducts 10 supervision visits per month and analysis shows that visits to the 3 lowest-performing facilities produce 80% of the quality improvement, those 3 visits should receive disproportionate investment of time and quality

Example: *A district health officer analyzed her work log and found she spent 40% of her time on routine administrative paperwork that she could train a clerical officer to handle. By delegating this Q3 activity, she reclaimed 2 days per week for supervision visits, which was her highest-value Q2 activity.*

C. Delegation — The Time Management Multiplier

Delegation is the most powerful time management tool available to a manager. It multiplies the manager's effective capacity by distributing work to others, while simultaneously developing staff skills and building organizational capacity. Yet it is one of the most underused management skills:

Delegation Step	Description	Common Error
1. Select the right task	Delegate tasks that are important but do not require the manager's specific authority, relationships, or expertise. Never delegate tasks that are confidential, require senior authority, or where the manager's personal judgement is essential	Delegating tasks that are genuinely the manager's responsibility — or refusing to delegate anything because 'I do it better'
2. Select the right person	Match the task complexity to the staff member's current readiness level (Hersey & Blanchard — Session 3). Delegation is also a development tool — stretch assignments build capability	Delegating always to the same person (the most capable) rather than developing others; delegating beyond a person's current readiness without adequate support
3. Delegate clearly	Communicate: What needs to be done? By when? To what standard? What resources are available? What authority does the person have? What decisions should they escalate?	Vague instructions that leave the staff member uncertain about expectations, authority, or the standard required
4. Provide support, not control	Check in appropriately without micromanaging. Provide resources and remove barriers. Be available for	Either abandoning the person (no support) or taking the task back at the first difficulty (micromanagement — which destroys the

	questions without taking the task back	delegation benefit and the person's confidence)
5. Follow up and Recognize	Review the completed task; provide constructive feedback; Recognize achievement publicly	Completing the task without recognizing the person's contribution; or providing only negative feedback without acknowledging what was done well

D. Meeting Management — Running Efficient and Effective Meetings

Meetings are the single largest consumer of management time in most health organizations, and the most frequently mismanaged. Effective meeting management is not a soft skill; it is a core managerial competency with direct financial implications:

- Before the meeting: Is the meeting necessary? (Can this be handled by email or a brief conversation?) Who must attend? (Keep it small 5-7 people maximum for decision-making meetings). What is the agenda? (Send it at least 24 hours before, with time allocated to each item and the desired outcome specified)
- Starting the meeting: Start on time always. Lateness is disrespectful of others' time and sets a culture of low accountability. Restate the purpose and the expected outcomes. Assign a timekeeper and a note-taker
- During the meeting: Stay on agenda; the chair's primary role is to manage time and participation, not to dominate discussion; park off-agenda issues in a 'parking lot' for separate follow-up; encourage quieter voices and manage dominant ones; close each agenda item with a clear decision or action
- Closing the meeting: End on time always. Summaries decisions made and actions agreed. Each action must have: a named responsible person; a specific deadline; a defined output. Meeting notes sent within 24 hours
- Meeting culture: Fewer, shorter, better-prepared meetings with better follow-through produce far better outcomes than frequent, long, unstructured meetings

V. MANAGING TIME IN CHALLENGING HEALTH CONTEXTS

A. Time Management in Resource-Limited and High-Pressure Settings

Health managers in low-resource settings like Sudan face specific time management challenges that are not captured in standard management textbooks. These require contextual adaptation:

- Infrastructure constraints: Power outages, internet connectivity failures, and transport breakdowns destroy planned schedules. Build buffer time into all plans (assume tasks will take 30-50% longer than expected due to infrastructure failures)
- Emergency demands: Disease outbreaks, security incidents, and humanitarian crises create legitimate Q1 demands that override planned schedules. Accept this as the reality of health management in fragile settings — but invest Q2 time in preparedness and response systems to reduce Q1 frequency and duration
- Social and cultural time expectations: In many Sudanese cultural contexts, immediate availability and social responsiveness are valued, which can conflict with the protected time needed for complex managerial work. Navigate this thoughtfully: communicate your planning time needs respectfully to staff and community members while remaining accessible for genuine priorities
- Multi-tasking temptation: Many managers believe they can manage multiple complex tasks simultaneously. Neuroscience is clear: humans cannot truly multi-task complex cognitive work.

What we call multi-tasking is rapid, costly task-switching. Protect single-focus time for complex thinking

Key Point: *The most effective health managers in high-pressure settings are not those who react fastest to every demand. They are those who have built the Q2 systems, staff capacity, and organizational habits that reduce the volume of Q1 demands — so they have the cognitive and temporal space to lead strategically rather than manage reactively.*

Practical Tool: Personal Time Audit — A One-Week Exercise
• This exercise develops self-awareness of how you actually spend your time — which is often very different from how you think you spend it.
• Step 1 — Time log: For 5 working days, record every activity in 30-minute blocks. Use a simple table: Time | Activity | Duration | Quadrant (Q1/Q2/Q3/Q4) | Energy level (High/Medium/Low)
• Step 2 — Categories: At the end of the week, assign each activity to a quadrant using the Eisenhower Matrix. Calculate what percentage of your week fell in each quadrant.
• Step 3 — Analyze time thieves: Identify your top 3 time thieves from the session content. How much time did each cost you this week?
• Step 4 — Apply the 80/20 rule: Which 3-5 activities produced the greatest Program value? What percentage of your week did you spend on them?
• Step 5 — Delegation audit: List every task you completed this week. For each, ask: Could a capable staff member have done this? If yes — why didn't they? What would need to change for me to delegate it?
• Step 6 — Personal time management plan: Write a 1-page personal time management plan for next month. Include: your top 3 Q2 activities that need protected time; your top 3 time thieves and how you will address them; 2 tasks you will delegate; your daily and weekly planning routine.

Case Study: Dr. Hawa's Overloaded Week — A Time Management Diagnostic
• Background: Dr. Hawa is the Program manager for a reproductive health Program covering 8 health facilities. She regularly works 60+ hours per week, is often the last to leave, and still feels behind on everything. Staff describe her as 'always busy but hard to reach for decisions.' Key supervision visits have been missed for 3 months. Strategic reports are consistently submitted late. Staff say they often cannot get her approval for routine matters.
• A typical week for Dr. Hawa: Monday: Attended 4 unplanned meetings (3 hours); wrote 2 reports that could have been delegated (2 hours); responded to 87 WhatsApp messages throughout the day (2 hours scattered). Tuesday: Travelled 4 hours round-trip to a meeting that could have been a phone call (4 hours). Wednesday: Re-did work submitted by a staff member because it was not done 'properly' (3 hours). Thursday: Attended a social function she felt obligated to attend (2 hours). Friday: Spent 5 hours on end-of-month administrative tasks that could be handled by a clerical officer.
• Question 1: Using the Eisenhower Matrix, classify each of Dr. Hawa's activities by quadrant. What percentage of her week is in each quadrant?
• Question 2: Identify Dr. Hawa's top 3 time thieves. For each, propose a specific, actionable strategy she could implement next week.

- Question 3: What does the fact that 'supervision visits have been missed for 3 months' tell you about Dr. Hawa's Q2 investment? What are the likely Program consequences?
- Question 4: Design a delegation plan for Dr. Hawa — identify 3 specific tasks from her week that she should delegate, who she should delegate them to, and what support she would need to provide.

Reflection / Discussion Questions

- Conduct a quick mental audit of your last 5 days. Estimate what percentage of your time was in each quadrant of the Eisenhower Matrix. What does this tell you about your current time management patterns?
- What is the difference between being 'busy' and being 'productive'? Describe a situation you have observed where high busyness co-existed with low productivity. What was the cause?
- Many health managers resist delegation because they feel 'it is faster to do it myself.' Is this true? Under what circumstances is it valid, and under what circumstances is it a dangerous habit? What are the long-term costs of not delegating?

Session Summary — Key Takeaways

- Time is the manager's scarcest, most non-renewable resource. Poor time management directly impairs Program performance — not through any single dramatic failure, but through the systematic neglect of high-value activities (supervision, planning, staff development) crowded out by low-value busyness
- The Eisenhower Matrix categorizes tasks by Urgency × Importance into four quadrants: Q1 (Do first — important & urgent); Q2 (Schedule — important & not urgent); Q3 (Delegate — urgent & not important); Q4 (Eliminate — neither). The goal is to shift time from Q1 and Q3 into Q2
- Seven common time thieves: unplanned interruptions; poorly managed meetings; unclear priorities; perfectionism; inability to say no; email/digital overload; procrastination. Each has specific, practical counter-strategies
- Key time management tools: Daily planning (10 min/day — 3 Must-Complete tasks); Weekly planning (30-60 min/week); The Pareto/80-20 Principle (identify the 20% of activities producing 80% of value and protect them); Delegation (the time management multiplier); Meeting discipline (agenda, start on time, end on time, actions documented)
- Delegation is the most powerful time management tool — it multiplies effective capacity while developing staff. The five delegation steps: select the right task; select the right person; delegate clearly; provide support without micromanaging; follow up and Recognize
- In resource-limited health settings: build buffer time for infrastructure failures; invest in Q2 preparedness to reduce Q1 crisis frequency; navigate cultural time expectations respectfully; protect single-focus time for complex thinking. The most effective managers build systems that reduce the volume of reactive demands — not just respond faster to them

Suggested Reading:

1. Covey SR (1989). The 7 Habits of Highly Effective People — Habit 3: Put First Things First. |
2. Drucker PF (1967). The Effective Executive — Chapter 2: Know Thy Time. |
3. Allen D (2001). Getting Things Done. | MSH (2008). Managers Who Lead — Chapter 7: Time and Priority Management.

Management & Leadership of Health Programs | BSc Public Health

Session 7

Human Resources Management & Conflict Resolution

Recruiting, Developing, Retaining Staff & Managing Workplace Conflict

Ahfad University for Women | Topic Two: Management Functions

Learning Outcomes

- Describe the human resource management cycle and explain each stage's importance for health Program performance
- Apply recruitment and selection principles to identify and appoint suitable health Program staff
- Design an effective performance management system including job descriptions, supervision, and appraisals
- Apply motivation theories (Maslow, Herzberg, McClelland) to improve staff engagement and retention
- Define conflict and distinguish between constructive and destructive conflict in health organizations
- Apply the Thomas-Kilmann conflict modes to select appropriate conflict resolution strategies
- Use the interest-based negotiation approach to resolve workplace conflicts effectively

I. HUMAN RESOURCES MANAGEMENT — THE FOUNDATION

A. Why HRM Is Central to Health Program Success

Health Programs do not deliver services, people do. The quality, motivation, and capability of human resources directly determines the quality of health services received by communities. A Program with excellent design, sufficient budget, and strong leadership will still fail if its human resources are inadequately recruited, poorly managed, and left without development or motivation.

Human Resource Management (HRM) in health Programs encompasses all the policies, practices, and systems that influence how people are attracted, developed, motivated, and retained to achieve Program objectives. It is not a support function; it is a core strategic function.

Figure: The Human Resource Management cycle — from planning to separation

II. HR PLANNING AND JOB DESIGN

A. HR Planning

HR planning ensures the Program has the right number of people, with the right skills, in the right places, at the right time. It involves analyzing current workforce capacity, projecting future requirements, and developing strategies to address gaps:

- Demand forecasting: What staff will be needed to implement the Program? What skills, at what level, in which locations?
- Supply analysis: What staff do we currently have? What are their skills? What are the gaps? What is our turnover rate?
- Gap analysis: Where is the difference between what we have and what we need? Are we overstaffed in some areas and understaffed in others?
- HR strategy: How will we address the gaps, through recruitment, training, redeployment, or contracting?

B. Job Design and Job Descriptions

A well-designed job description is the foundation of every other HRM activity, it defines the role clearly so it can be recruited for, supervised against, appraised on, and trained toward. A complete job description includes:

JD Component	Description	Example — Community Nutrition Volunteer
Job title	Clear, specific title that reflects level and function	Community Nutrition Volunteer — Kassala State
Purpose statement	One sentence describing why this role exists	To provide household-level nutrition counselling and screening to children and pregnant women in assigned communities
Key responsibilities	5-8 specific, action-oriented duties using strong verbs	Conduct monthly growth monitoring for all children under 5 in assigned 50 households; screen for acute malnutrition using MUAC; refer severe cases to OTP; deliver IYCF counselling messages; maintain accurate household registers
Reporting relationships	Who the person reports to and who (if anyone) reports to them	Reports to: Health Facility In-Charge. No direct reports.
Required qualifications	Minimum education, experience, and skills	Secondary school certificate; female; resident of target community; able to read and write in Arabic; completed community health volunteer training
Desirable qualifications	Additional attributes that would strengthen the candidate	Previous experience as CHW; basic literacy in English; experience with community groups
Conditions of service	Working hours, location, compensation, benefits	Part-time voluntary role; monthly incentive of SDG X; provision of MUAC tape, register, and IEC materials

III. RECRUITMENT, SELECTION, AND ONBOARDING

A. Recruitment

Recruitment is the process of attracting a pool of qualified candidates for a vacant position. Effective recruitment requires reaching the right candidates through appropriate channels:

- Internal recruitment: Advertising vacancies to existing staff before going external. Advantages: faster, lower cost, motivates existing staff, candidate already knows the organization. Disadvantages: may limit fresh perspectives; can create internal competition tensions
- External recruitment: Advertising through job boards, community networks, professional associations, universities, and social media. Necessary for new skills or when internal candidates are not available
- In health Program contexts: Community-based recruitment (for community health workers) requires different channels — community leaders, women's groups, and mosque/church networks are often more effective than formal job postings

B. Selection

Selection is the process of choosing the best-fit candidate from the applicant pool. Effective selection uses multiple methods to assess candidates against the job requirements:

Selection Method	What It Assesses	Advantages	Limitations & Best Use
Structured interview	Technical knowledge; situational judgement; communication; motivation	Flexible; allows follow-up; assesses interpersonal skills directly	Prone to interviewer bias; consistency requires structured questions. Use standardized questions with scoring rubrics for all candidates
Written test / knowledge assessment	Technical knowledge and analytical skills	Objective; comparable across candidates; reduces interviewer bias	Assesses knowledge, not necessarily performance. Best combined with interview
Skills demonstration / practical test	Ability to perform specific tasks (e.g., MUAC measurement; HMIS data entry; presentation skills)	Most valid predictor of actual job performance; objective	Requires preparation; not practical for all roles. Ideal for technical and clinical positions
Reference checks	Past performance; reliability; conduct	Validates candidate's claims; provides behavioral history	References are often positive by selection. Ask specific behavioral questions rather than general impressions
Panel interview	Broader assessment; reduces individual bias	Multiple perspectives; more fair; reduces single-interviewer bias	Requires coordination; can be intimidating for candidates; ensure panel is diverse

C. Onboarding

Onboarding is the process of integrating a new employee into the organization and their role. Research consistently shows that the first 90 days are critical for long-term staff success and retention:

- Day 1: Welcome; introduce to team; workplace tour; administrative setup (ID, computer access, uniform). First impressions are lasting — make them positive
- Week 1: Role orientation — review the JD, work plan, key contacts, and reporting systems; introduce to key stakeholders; review organizational policies
- Month 1: Technical orientation — Program protocols, tools, and systems; supervised practice; begin building key relationships; first check-in meeting with supervisor
- Month 2-3: Increasing independence with regular supervision; first performance conversation; begin contributing to team activities; identify early development needs

Key Point: *Studies show that 20% of staff turnover occurs within the first 45 days of employment — almost always due to poor onboarding, not poor selection. Investment in onboarding protects the recruitment investment and accelerates time-to-productivity.*

IV. PERFORMANCE MANAGEMENT

A. The Performance Management System

Performance management is the ongoing process of setting clear expectations, monitoring performance, providing feedback, and developing staff to achieve their full potential. It is not an annual event — it is a continuous management responsibility:

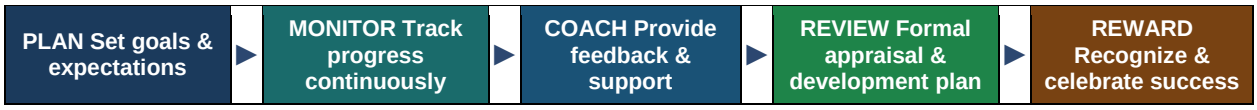
PLAN Set goals & expectations
MONITOR Track progress continuously
COACH Provide feedback & support
REVIEW Formal appraisal & development plan
REWARD Recognize & celebrate success

Figure: The performance management cycle — continuous, not annual

PM Component	Description	Health Program Application
Performance planning	Setting clear, measurable goals at the start of a period; agreeing expectations; establishing the 'what' and 'how' of the role	At the start of each quarter, supervisor and staff member agree on 3-5 priority goals with measurable indicators. Both sign the plan to signal mutual commitment
Ongoing supervision	Regular one-on-one meetings to review progress, discuss challenges, and provide support. Should be scheduled — not only triggered by problems	Monthly 30-minute individual supervision meetings for each direct report. Focus: What is going well? What is challenging? What support do you need?
Feedback — formal and informal	Timely, specific, honest, and constructive feedback on performance — both positive and developmental. Feedback should be given close to the event, not saved for the annual review	'The household register you submitted was very complete this month — I particularly appreciated the accuracy of the MUAC measurements.' Or: 'I noticed the last 3 supervision reports were submitted late — let's talk about what is making that difficult'
Performance appraisal	Structured, periodic review of overall performance against agreed goals. Documents	Annual formal appraisal: review of goals achieved vs. planned; competency assessment;

	achievements, identifies development needs, and informs HR decisions	identification of next year's goals; agreement of development plan for the coming year
Performance improvement	When a staff member is not meeting expectations, a formal process to identify causes, agree on required changes, provide support, and set a review timeline	Performance Improvement Plan (PIP): 90-day plan with clear performance expectations, support measures, and review date. Used only after informal coaching has not resolved the issue

V. MOTIVATION THEORIES AND STAFF RETENTION

A. Why Motivation Matters

Motivation determines how much effort people invest in their work. Two staff members with identical skills and resources will produce very different results depending on their level of motivation. Understanding what motivates health workers, and what demotivates them, is one of the most important competencies a health Program manager can develop.

B. Maslow's Hierarchy of Needs

Abraham Maslow (1943) proposed that human needs are organized in a hierarchy, and that people are motivated primarily by their lowest unmet need. Once a need is met, it no longer motivates, and the person is motivated by the next level:

Maslow Level	Need Type	Examples	Health Program Implication
Level 5: Self-Actualization	Personal growth, fulfilment, reaching full potential	Challenging work; learning opportunities; meaningful contribution; creative expression	Provide opportunities for leadership, innovation, and professional growth. Staff who feel they are growing and contributing at their best potential are highly motivated
Level 4: Esteem	Recognition, respect, status, achievement	Public recognition; title; authority; positive performance feedback	Recognize achievements publicly and privately; create formal recognition systems; give staff increasing responsibility as they develop
Level 3: Social/Belonging	Connection, relationships, teamwork, acceptance	Team membership; collegial relationships; supportive supervisor; community belonging	Build a positive team culture; ensure new staff are welcomed; address interpersonal conflicts quickly; celebrate team achievements
Level 2: Safety & Security	Job security, safe working environment, predictability	Contract stability; safe facilities and transport; clear policies; absence of harassment	Ensure employment contracts are clear and respected; provide safe working conditions and transport for outreach; maintain predictable schedules
Level 1: Physiological	Basic survival needs: food, water, shelter, rest	Adequate salary; regular payment; leave entitlement	Pay staff what was promised, on time, every time. No amount of recognition compensates for delayed or inadequate pay

Remember: *In health Program contexts, many community health workers and lower-cadre staff are operating at Level 1 and 2 — their basic and security needs are not fully met. Motivational strategies that work for well-compensated professionals (Level 4-5 appeals) will not motivate staff whose basic needs are unmet. Always assess which level your staff are primarily operating at.*

C. Herzberg's Two-Factor Theory

Frederick Herzberg (1959) distinguished between two types of factors affecting work motivation:

Factor Type	Description	Examples	Management Implication
HYGIENE FACTORS (Dissatisfiers — absence causes dissatisfaction, presence does not motivate)	Basic working conditions that must be adequate to prevent dissatisfaction — but do not in themselves create motivation or satisfaction	Salary; job security; company policy; supervision quality; working conditions; relationships with colleagues	Fix hygiene factors first — inadequate salary, poor working conditions, unfair policies, or bad supervision will actively demotivate. But improving them beyond adequate does not generate greater motivation
MOTIVATOR FACTORS (Satisfiers — presence creates satisfaction and motivation, absence does not cause dissatisfaction)	The intrinsic content of the work itself — what makes work meaningful, challenging, and rewarding	Achievement; recognition; the work itself (interesting, challenging); responsibility; advancement; growth	Once hygiene factors are adequate, increase motivators: design challenging, meaningful work; provide recognition; increase responsibility; create career development pathways

Key Point: *Herzberg's insight: You cannot motivate by money alone — but you will certainly demotivate by insufficient or unfair pay. Fix the hygiene factors, then invest in motivators. A well-paid, unchallenged, unrecognized health worker is not a motivated health worker.*

VI. CONFLICT IN HEALTH ORGANIZATIONS

A. What Is Conflict?

Conflict occurs when two or more individuals or groups perceive incompatible goals, needs, or interests, and experience tension as a result. Conflict is inevitable in health organizations, different professional backgrounds, resource competition, role overlap, and value differences guarantee it. The question is not whether conflict will occur, but whether it will be managed constructively or destructively.

Conflict Type	Description	Health Program Example
Constructive conflict	Disagreement that challenges assumptions, generates creative solutions, and improves decision quality. Productive when well-managed	Debate among Program staff about whether to expand geographic coverage or deepen quality in current areas — producing a better, evidence-based decision about Program focus
Destructive conflict	Personalized, emotional conflict that damages relationships, reduces teamwork, and impairs performance	A dispute between two senior officers about who should lead a new Program component degenerates into personal attacks, affecting team cohesion and Program delivery
Task conflict	Disagreement about the content, goals, or methods of work — can be constructive if well-managed	Disagreement about the most appropriate outreach strategy for reaching nomadic communities
Relationship conflict	Personal, interpersonal friction based on emotions, personalities, and values — almost always destructive	Persistent animosity between two team members that affects team meetings, decision-making, and morale
Process conflict	Disagreement about how work should be organized, delegated, and executed	Conflict about reporting lines in a newly restructured Program team

B. Thomas-Kilmann Conflict Modes — Selecting the Right Style

Kenneth Thomas and Ralph Kilmann identified five conflict-handling modes based on two dimensions: assertiveness (the degree to which you pursue your own concerns) and cooperativeness (the degree to which you attend to others' concerns). No single mode is universally best, effective conflict managers select the appropriate mode for the situation:

	LOW COOPERATIVENESS	HIGH COOPERATIVENESS
HIGH ASSERTIVENESS	**COMPETING (Win-Lose)** High assertiveness, low cooperation. Pursuing own goals at others' expense. Useful in genuine emergencies or when you must defend core principles.	**COLLABORATING (Win-Win)** High assertiveness, high cooperation. Working together to find a solution that fully satisfies both parties. Ideal for complex issues where both parties have important concerns.
LOW ASSERTIVENESS	**AVOIDING (Lose-Lose)** Low assertiveness, low cooperation. Neither pursuing own nor others' concerns. Useful only for trivial issues or when you need time to de-escalate.	**ACCOMMODATING (Lose-Win)** Low assertiveness, high cooperation. Yielding to others' wishes. Useful when the issue matters more to the other party, or when preserving relationship outweighs the outcome.
	COMPROMISING (Middle Ground) — Moderate assertiveness & cooperation. Each party gives up something. Useful when a quick, mutually acceptable solution is needed. 'Split the difference.'	

Figure: Thomas-Kilmann Conflict Mode Instrument — five conflict handling styles

Conflict Mode	When to Use	When NOT to Use
COMPETING	Emergency requiring quick decision; defending a critical principle; when you are right and the stakes are high	Routine disagreements; when relationship matters more than the outcome; when the other party's expertise exceeds yours on this issue
COLLABORATING	Complex issues where both parties' concerns are important; long-term relationship matters; creative solutions are needed	When time is short; when the issue is too trivial to warrant the investment; when the other party is not willing to collaborate
COMPROMISING	When both parties have roughly equal power and mutually exclusive goals; when time is important; as a temporary agreement	When one party is clearly right; when long-term relationship and full solution are more important than speed; do not use as a default to avoid real resolution
AVOIDING	Trivial issues; when you need time to de-escalate; when gathering more information is needed	Important issues; when avoiding will allow the conflict to escalate; when a decision is urgently needed
ACCOMMODATING	When you are wrong; when the issue matters more to the other party; when preserving the relationship is paramount	When your own concerns are equally important; when accommodation will be seen as weakness and invite future exploitation

C. The Interest-Based Negotiation Approach

Interest-based negotiation (Fisher & Ury, 'Getting to Yes', 1981) is the most effective framework for resolving significant workplace conflicts. It distinguishes between positions (what people say they want) and interests (the underlying needs and concerns that drive their position):

- Separate people from the problem: Address the conflict as a shared problem to be solved together, not as a battle between people. 'We have a problem to solve' not 'You are the problem.'
- Focus on interests, not positions: Ask 'Why?' to understand the underlying need. Two colleagues competing for the same office (position) may have underlying interests (privacy for phone calls; storage space; proximity to the team) that could both be satisfied by a different arrangement
- Generate options for mutual gain: Brainstorm creative solutions that could satisfy both parties' interests before evaluating any of them. Avoid anchoring on one solution too early
- Use objective criteria: Evaluate options against objective standards (policy, professional norms, data, equity principles) rather than personal preferences or power
- BATNA — Best Alternative To a Negotiated Agreement: Know what you will do if negotiation fails. A strong BATNA gives you confidence; a weak BATNA requires flexibility and creativity

Practical Tool: Conflict Resolution Role Play

- Scenario: Two health workers in a district office are in persistent conflict. Amira (senior nurse, 8 years' experience) believes that Dr. Khalid (recently hired physician) consistently undermines her authority in front of patients and junior staff — taking over clinical decisions that she is qualified to make independently. Dr. Khalid believes Amira is resistant to the new clinical protocols he has introduced and is 'stuck in old ways' of working.
- The conflict has been escalating for 6 weeks. Morale in the team is affected. A patient complaint cited 'staff arguing' as a concern. The facility in-charge has asked both parties to participate in a mediated conversation.
- Step 1 (Individual preparation, 5 minutes): Each participant identifies their POSITION (what they are saying they want) and their INTERESTS (what they actually need — the underlying concerns). What is their BATNA if mediation fails?
- Step 2 (Mediated dialogue, 15 minutes): The mediator (a third student) facilitates using interest-based negotiation. Rules: one person speaks at a time; no interruptions; mediator can reframe statements; focus on interests, not positions.
- Step 3 (Agreement, 5 minutes): The group generates 3 potential agreements that address both parties' interests. Select the best one and write it down as a specific, actionable agreement.
- Debrief questions: Which Thomas-Kilmann conflict mode did each party initially use? Which mode did the mediator encourage? What was the most important interest that, once understood, opened the door to resolution?

Case Study: Staff Motivation Crisis — Rebuilding a Demoralized Team

- Context: A health Program in South Kordofan has experienced 40% staff turnover in the last year. Exit interviews reveal: staff felt unrecognized and under-valued; salaries were consistently paid 2-3 weeks late; the previous manager never gave feedback except when things went wrong; staff had no opportunity for training or advancement; and interpersonal conflicts were left to fester for months without management intervention.
- The new manager has been asked to rebuild the team. She has a limited additional budget — she cannot substantially increase salaries. She must improve motivation and retention with primarily non-financial tools.

- Question 1: Using Maslow's hierarchy, identify which unmet needs most likely drove staff turnover. Which need is the most urgent to address first, and why?
- Question 2: Using Herzberg's two-factor theory, classify the exit interview complaints as hygiene factors or motivators. What does this tell you about the priority order of interventions?
- Question 3: Design a 3-month staff motivation action plan for the new manager. Include: 3 actions to address hygiene factors; 3 actions to enhance motivators. For each action, specify who is responsible, what will be done, and by when.
- Question 4: Two team members are in a persistent conflict that is disrupting team meetings. The new manager identifies it as a relationship conflict. Using the Thomas-Kilmann framework, which conflict mode would you recommend the manager use — and why?

Reflection / Discussion Questions

- Think of a job you have held or a volunteer role you have taken. Using Maslow's hierarchy and Herzberg's two-factor theory, what motivated you most? What demotivated you? What would a manager have needed to do differently to keep you more engaged?
- What is the difference between conflict avoidance and conflict resolution? Why is avoiding conflict often worse than addressing it directly — even when direct conversation feels uncomfortable?
- A manager says: 'I treat all my staff the same — same feedback, same development opportunities, same management approach. That is fair.' Is this fair? Is it effective? What would you say to this manager?

Session Summary — Key Takeaways

- Human Resource Management covers the full cycle: HR planning; job design; recruitment and selection; onboarding; performance management; learning and development; retention; and separation. People are the most critical resource in health Programs — and the most consistently under-managed
- Job descriptions are the foundation of HRM — they define the role, enable effective recruitment, guide supervision and appraisal, and identify training needs. A JD without clear, measurable responsibilities is not a useful management tool
- The performance management cycle is continuous: Plan → Monitor → Coach → Review → Reward. Annual appraisals alone are insufficient. Monthly supervision conversations, timely specific feedback, and recognition close to the achievement are the primary performance management tools
- Motivation theories: Maslow (hierarchy of needs — unmet lower-level needs must be addressed before higher-level motivators work); Herzberg (hygiene factors prevent dissatisfaction; motivators create satisfaction — fix hygiene first, then invest in motivators). Apply these by diagnosing which level your staff are primarily operating at
- Conflict is inevitable — the goal is to manage it constructively. Thomas-Kilmann five modes: Competing; Collaborating (Win-Win — ideal for complex issues); Compromising; Avoiding; Accommodating. Mode selection depends on urgency, stakes, and relationship importance
- Interest-based negotiation (Fisher & Ury): Separate people from the problem; focus on interests not positions; generate options for mutual gain; use objective criteria; know your BATNA. The most powerful conflict resolution tool in health Program management

Suggested Reading:

1. Maslow AH (1943). A Theory of Human Motivation. Psychological Review. |
2. Herzberg F (1968). One More Time: How Do You Motivate Employees? Harvard Business Review. |
3. Fisher R & Ury W (1981). Getting to Yes. |
4. Thomas KW & Kilmann RH (1974). Thomas-Kilmann Conflict Mode Instrument. |
5. MSH (2008). Managers Who Lead — Chapter 8: Managing People. | WHO (2010). Increasing Access to Health Workers in Remote and Rural Areas.

Management & Leadership of Health Programs | BSc Public Health

Session 8

Team Building

Building High-Performance Teams in Health Programs

Ahfad University for Women | Topic Two: Management Functions

Learning Outcomes

- Define a team and distinguish effective teams from groups of individuals working independently
- Apply Tuckman's stages of team development to diagnose a team's current stage and adapt leadership accordingly
- Describe Belbin's team roles and explain why diverse roles are essential for team effectiveness
- Identify the characteristics of high-performing health Program teams and the barriers to team effectiveness
- Apply practical team-building strategies to develop cohesion, trust, and collective performance
- Design an effective team meeting structure that builds shared understanding and accountability
- Recognize the leadership behaviour that build and sustain high-performing teams over time

I. WHAT IS A TEAM?

A. Teams vs. Groups — A Critical Distinction

A team is more than a group of people who share a workspace or report to the same manager. A team is a small number of people with complementary skills who are committed to a common purpose, shared performance goals, and a common approach for which they hold themselves mutually accountable (Katzenbach & Smith, 1993).

Most health Program 'teams' are actually groups, collections of individuals who happen to work in proximity but operate largely independently, without shared goals, mutual accountability, or genuine collaboration. The difference in performance between a real team and a group is enormous:

Dimension	Work Group	High-Performing Team
Goal	Individual goals; shared only in name	Genuinely shared team goals that members feel collectively responsible for
Accountability	Individual accountability only	Individual AND mutual team accountability members hold each other accountable
Output	Sum of individual contributions	Collective work products that could not be produced by individuals working alone
Skills	Random or complementary by chance	Deliberately complementary, technical, functional, and interpersonal skills balanced

Decision-making	Manager decides; group implements	Team makes decisions together within agreed boundaries
Communication	Formal, hierarchical, manager-centered	Open, multi-directional, based on trust and psychological safety
Health Program example	Each health worker manages their own facility independently; manager collects reports monthly	Weekly team review of coverage data; shared problem-solving on bottlenecks; peer support; collective accountability for district targets

Key Point: *Building a real team — rather than managing a group of individuals — is one of the highest-return investments a health Program manager can make. Teams consistently outperform the sum of their individual members' capabilities on complex tasks.*

II. TUCKMAN'S STAGES OF TEAM DEVELOPMENT

Bruce Tuckman (1965) identified four stages through which most teams pass as they develop — later adding a fifth stage. Understanding these stages helps managers anticipate team dynamics, adapt their leadership approach, and accelerate team development:

FORMING	STORMING	NORMING	PERFORMING	ADJOURNING
Orientation Polite, cautious Roles unclear High dependency on leader	Conflict Competing ideas Power struggles Low morale possible	Cohesion Roles clarified Norms established Cooperation grows	High performance Autonomous Flexible & creative Leader delegates	Closure Task completion Team dissolution Reflection & recognition
◄ *Team performance generally increases as it progresses through the stages* ►				

Figure: Tuckman's stages of team development — Forming, Storming, Norming, Performing, Adjourning

Stage	Team Characteristics	Manager's Primary Role	Key Actions
FORMING	Polite, careful, uncertain. Members are getting to know each other. High dependence on the leader for direction. Individual roles unclear. Excitement mixed with anxiety	Director — provide structure, clarity, and direction. High task direction, high relationship support (S2: Coaching from Session 3)	Clarify purpose, goals, and roles; establish team norms and ways of working; create opportunities for members to get to know each other; communicate your own expectations and leadership approach clearly
STORMING	Conflict emerges, about roles, approaches, power, and values. Some members may challenge the leader. Subgroups may form. Morale may dip. This is normal and necessary	Coach, acknowledge the conflict; facilitate constructive dialogue; maintain focus on shared goals; model the values you want the team to develop	Name the conflict constructively: 'It is normal for teams to have challenging conversations at this stage.' Facilitate dialogue; use conflict resolution skills (Session 7); help the team establish norms for disagreement
NORMING	Team finds its rhythm. Norms are established, how we work, how we disagree, how we communicate. Roles become clear. Cooperation increases. Trust builds	Supporter — step back from directing; facilitate team problem-solving; Recognize and reinforce positive team behaviour	Celebrate early team wins; formalize effective norms; encourage members to support each other; create space for the team to make decisions without the manager's involvement

PERFORMING	High performance. Team operates with significant autonomy. Members are flexible and adaptive. Conflicts are resolved within the team without escalation. Creative problem-solving flourishes	Delegator — set direction and boundaries; then get out of the way. Focus on removing external barriers; represent the team to senior leadership	Delegate significant responsibility; provide stretch assignments; protect the team from external interference; give the team credit for its achievements; focus on the next challenge to maintain engagement
ADJOURNING	Team completes its task or is disbanded. Members experience a range of emotions, pride, grief, uncertainty. Relationships formed during the team's life are valuable	Celebrator and transition facilitator, Recognize achievements; help members move to new roles with confidence	Formally mark the team's completion; celebrate achievements; provide individual feedback and development recommendations; help members apply lessons to their next roles

Remember: *Teams do not move through Tuckman's stages in a clean, linear progression. A team that has reached Performing can be thrown back to Storming by a significant membership change, a crisis, or a major goal shift. Managers must continuously monitor team stage and adapt their leadership accordingly.*

III. BELBIN'S TEAM ROLES

Dr. Meredith Belbin's research at Henley Business School identified nine distinct team roles that are needed for a team to perform at its best. No role is inherently superior, all are necessary. Individual team members naturally prefer certain roles and can play secondary roles when needed. A team with too many members in similar roles, or with major role gaps, will underperform:

THINKING ROLES	ACTION ROLES	PEOPLE ROLES
• Plant — Creative, imaginative, unorthodox. Solves difficult problems	• Shaper — Dynamic, challenging. Thrives on pressure; drives action	• Coordinator — Mature, confident. Clarifies goals; promotes decision-making
• Monitor Evaluator — Sober, strategic, discerning. Judges options fairly	• Implementer — Disciplined, reliable. Turns ideas into practical action	• Teamworker — Cooperative, mild, perceptive. Listens; builds team spirit
• Specialist — Single-minded, dedicated. Provides rare knowledge and skill	• Completer-Finisher — Painstaking, conscientious. Finds errors; ensures quality completion	• Resource Investigator — Extrovert, enthusiastic. Explores opportunities; develops contacts

Figure: Belbin Team Roles — nine roles across three categories

Role	Contribution to Team	Allowable Weakness	Health Program Application
Plant	Generates creative, unconventional ideas and solutions to difficult problems	May be impractical; poor at communicating; ignores incidentals	Critical for innovation — designing new outreach approaches; generating solutions to persistent coverage barriers
Monitor Evaluator	Provides logical, impartial analysis; sees all options; judges accurately	Lacks drive; doesn't inspire others; overly critical	Essential for evaluating Program options, risk assessment, and quality review

			— the team's critical analytical voice
Specialist	Provides deep knowledge in a specific field — clinical, technical, or methodological	Narrow contribution; single-minded; dwells on technicalities	The technical expert (epidemiologist, clinician, supply chain specialist) whose expertise others depend on
Shaper	Challenges the team to move forward; drives action; thrives under pressure	Prone to provocation; offends others' feelings; impatient	Drives implementation when the team risks paralysis; the person who pushes to move from planning to action
Implementer	Turns ideas into practical, achievable plans; reliable and disciplined	Inflexible; slow to respond to new possibilities	Essential for work planning — the person who converts strategy into a detailed, executable work plan and follows through
Completer-Finisher	Ensures accuracy and quality; finds errors; meets deadlines	Reluctant to delegate; over-anxious; perfectionist	Catches errors in reports and Program documents; ensures quality of data submitted; manages deadline compliance
Coordinator	Clarifies goals; promotes decision-making; ensures all voices heard; confident	Can be seen as manipulative; offloads own work	The meeting facilitator; the person who ensures the team's energy is directed toward shared goals; natural chair
Teamworker	Listens, builds team harmony, supports others; cooperative and diplomatic	Indecisive in crisis; avoids confrontation	Maintains team morale during difficult periods; bridges conflicts; makes everyone feel heard and valued
Resource Investigator	Explores external opportunities; builds networks; enthusiastic communicator	Over-optimistic; loses interest after initial enthusiasm	The team's connector to external partners, donors, and communities; drives partnership development

Key Point: *Most health Program teams are too small for every member to fill a single Belbin role. In practice, each team member plays 2-3 roles depending on the task context. The value of Belbin is diagnostic: it helps identify role gaps (e.g., 'we have no Completer-Finisher, which explains why we always miss quality checks') and role imbalances (e.g., 'we have four Shapers and no Implementer — which explains our implementation failures despite good ideas').*

IV. CHARACTERISTICS OF HIGH-PERFORMING HEALTH TEAMS

A. The Five Dysfunctions of a Team (Patrick Lencioni)

Patrick Lencioni's research identified five dysfunctions, in a pyramid structure, that most commonly undermine team performance. Each dysfunction builds on the one below it: if the base is absent, the higher levels cannot develop:

Dysfunction (Base to Top)	Description	Health Program Manifestation	Counter-measure
1. Absence of Trust (Foundation)	Team members are unwilling to be vulnerable — to admit mistakes, weaknesses, or uncertainty. Without trust, everything above fails	Staff do not raise problems with the manager; errors are hidden; no one admits they do not know how to perform a new task	Build vulnerability-based trust: model it yourself (admit mistakes; ask for help); create psychological safety; team exercises that build genuine connection
2. Fear of Conflict	Without trust, teams do not engage in genuine ideological debate. Disagreements are avoided, producing artificial harmony over real alignment	Program meetings are polite but unproductive — everyone agrees publicly; disagreements happen in corridors after the meeting. Poor decisions result from lack of challenge	Distinguish constructive from destructive conflict; make it safe to disagree; actively invite alternative views; model healthy disagreement yourself
3. Lack of Commitment	Without productive conflict, team members do not commit to decisions — they nod in meetings but do not act outside them. Ambiguity persists	Decisions made in team meetings are not acted on; staff implement their own interpretation rather than the agreed approach; plans diverge from reality quickly	Close every meeting with clear decisions; ensure everyone has a voice before the decision; follow up on commitments; address non-compliance directly
4. Avoidance of Accountability	Without commitment, team members do not hold each other accountable for standards — they wait for the manager to be the accountability mechanism	Staff watch a colleague perform below standard and say nothing — 'it is not my problem.' The manager becomes the sole enforcer of standards	Create shared performance standards; empower team members to hold each other accountable; address the dysfunctional norm that 'only the manager can give feedback'
5. Inattention to Results (Top — the ultimate failure)	Without mutual accountability, team members prioritise individual goals (career advancement, personal recognition, comfort) over team results	A team member focuses on activities that make them look good to senior management rather than on the team's shared performance goals	Make collective results visible; celebrate team successes; align individual incentives with team performance; call out individual agenda-setting that harms the team

V. BUILDING HIGH-PERFORMING TEAMS — PRACTICAL STRATEGIES

A. Team Charter Development

A team charter is a foundational document that a new (or struggling) team develops together, establishing shared agreements about how it will work. The process of developing it is as valuable as the document itself, it surfaces assumptions, builds trust, and creates genuine commitment:

- Purpose and goals: What are we here to achieve? What does success look like? How will we know?
- Roles and responsibilities: Who does what? What decisions can each person make independently? What requires team input?
- Ways of working: How will we make decisions? How will we run meetings? How will we communicate? What is our norm for response time to messages?
- Norms for disagreement: How will we handle conflict? What behaviour is acceptable and unacceptable in team discussions?
- Accountability: How will we hold each other accountable? What happens if commitments are not met?
- Learning and improvement: How will we reflect on our performance? How will we share learning within the team?

B. Psychological Safety — The Foundation of Team Learning

Amy Edmondson's landmark research (Harvard Business School, 1999), later validated by Google's Project Aristotle, identified psychological safety as the single most important predictor of team learning and performance. Psychological safety is the shared belief that the team is safe for interpersonal risk-taking: that members can speak up, admit mistakes, ask questions, or challenge assumptions without fear of punishment or humiliation.

- Paradox of safety: Edmondson found that the best-performing medical teams reported more errors, not because they made more errors, but because they felt safe to report them. Teams with low psychological safety under-report errors, hide performance problems, and do not learn
- Building psychological safety: Model vulnerability (admit your own uncertainties and mistakes); respond to problems with curiosity, not blame; explicitly invite different views; make it safe to say 'I don't know'; thank people who raise concerns
- Destroying psychological safety: Public humiliation when someone makes a mistake; dismissing ideas without consideration; penalizing people who raise problems; consistently favoring certain voices over others

Example: *A health center in-charge holds a monthly team reflection meeting where she opens by sharing one mistake she made that month and what she learned from it. Over 6 months, staff began sharing their own mistakes — and the team's error rate decreased because problems were caught and corrected earlier.*

C. Effective Team Meetings

Team meetings are the primary venue for team coordination, problem-solving, and accountability — and one of the most frequently mismanaged aspects of health Program team leadership. An effective team meeting structure for health Programs:

Meeting Type	Frequency	Duration	Purpose	Structure
Daily stand-up / brief check-in	Daily (where team is co-located)	10-15 minutes	Coordinate daily activities; surface immediate blockers; quick information sharing	Each person: (1) What did I do yesterday? (2) What am I doing today? (3) Any blockers? No discussion — issues flagged here are resolved in separate meetings
Weekly team review	Weekly	60 minutes	Review Program progress against work plan; problem-solve bottlenecks; share learning; coordinate cross-team activities	Agenda: (1) Progress review against work plan — 20 min; (2) Key challenges and solutions — 20 min; (3) Information sharing — 10 min; (4) Actions and accountability — 10 min
Monthly performance review	Monthly	90-120 minutes	Review performance data; assess progress against indicators; identify trends; strategic problem-solving	Agenda: (1) Data review — indicators dashboard — 30 min; (2) Analysis of key trends — 20 min; (3) Deep dive on 1-2 priority challenges — 30 min; (4) Actions — 20 min
Quarterly team reflection	Quarterly	Half day	Review progress against strategic goals; team learning and development; adjust plans; celebrate achievements	After-action review format: What did we plan? What happened? Why the difference? What will we do differently next quarter?

VI. DIVERSITY AND INCLUSION IN HEALTH TEAMS

Health Program teams that reflect the diversity of the communities they serve in gender, background, expertise, and perspective consistently produce better decisions, more innovative solutions, and more equitable services. In Sudan's context, several dimensions of diversity are particularly important:

- Gender diversity: Women managers and community health workers are more effective in many health Program contexts particularly maternal and reproductive health. Organizations should set explicit targets for women in leadership, provide mentoring and flexibility, and address structural barriers to women's advancement
- Professional diversity: Health Programs need both clinical and public health expertise, technical specialists and generalists, field workers and analysts. Resist the tendency to hire people who think and work like existing team members
- Community representation: Teams working with specific communities, nomadic pastoralists, displaced populations, specific ethnic groups, should include members from those communities. This builds trust, improves cultural appropriateness, and surfaces knowledge that outsiders cannot access
- Inclusion vs. diversity: Diversity is having different people in the room. Inclusion is ensuring all those people's voices are genuinely heard, valued, and influential. A diverse team with low psychological safety produces neither equity nor innovation

Practical Tool: Team Diagnostic Exercise

- This exercise helps identify your team's current strengths and development areas using Tuckman's stages, Belbin's roles, and Lencioni's dysfunctions framework.
- Part 1 — Tuckman Stage Assessment (Individual, 5 minutes): Read the description of each Tuckman stage. Which stage best describes your current team (or a team you are familiar with)? What specific observations or experiences lead you to this conclusion?
- Part 2 — Belbin Role Mapping (Small group, 10 minutes): Think of a team you know (your student group, a work team, or a community group). For each of the 9 Belbin roles, identify: (a) who in the team most naturally fills this role; (b) which roles are absent or weak. What impact do the role gaps have on team performance?
- Part 3 — Lencioni Dysfunction Assessment (Individual, 5 minutes): Rate your team on a scale of 1-5 for each of Lencioni's five dysfunctions (1 = this dysfunction is absent; 5 = this dysfunction is severe). Which dysfunction is your team's most critical to address?
- Part 4 — Team Development Plan (Pair, 10 minutes): Based on your assessment, design a 90-day team development plan. Include: 2 actions to strengthen the foundation dysfunction identified; 1 team charter element to develop; 1 change to your team meeting structure.
- Class debrief: What themes emerge across teams? Which of the three frameworks (Tuckman, Belbin, Lencioni) do students find most useful for diagnosing their team's challenges?

Case Study: Building a New District Health Team — A Leadership Challenge

- Context: Dr. Rania has just been appointed as district health officer for a newly created district in Blue Nile state. She has inherited a team of 7 health workers who previously reported to three different supervisors and have never functioned as a coordinated team. The district has poor health indicators: immunization coverage 55%; ANC 3+ visits 38%; skilled birth attendance 42%.
- Team composition: 2 experienced nurses (15+ years), both resistant to change; 1 mid-level health officer (5 years, highly ambitious, impatient); 2 recent graduates (6 months, eager but uncertain); 1 administrative officer (technical skills moderate, excellent with data); 1 community liaison officer (no health background, exceptional community relationships).
- Question 1: Using Tuckman's model, which stage is this team currently in? What specific leadership behaviour does Dr. Rania need to priorities in her first month?
- Question 2: Map the team's Belbin roles based on the descriptions given. Which roles are well-represented? Which are absent or weak? What does this suggest about where the team will struggle?
- Question 3: Dr. Rania wants to hold a team charter development workshop in her first week. Design a 3-hour agenda for this workshop, including the key questions the team needs to address.
- Question 4: In the second week, a conflict erupts in a team meeting between one of the experienced nurses and the ambitious mid-level officer about who should lead the immunization campaign. Applying Tuckman and Lencioni, what is happening and how should Dr. Rania respond?

Reflection / Discussion Questions

- Think of the most effective team you have ever been part of (in any context — school, work, community, sport). What made it effective? Can you identify which Tuckman stage it was at? Which Belbin roles were represented? Which of Lencioni's dysfunctions were absent?
- What is the difference between a team meeting that builds team performance and a meeting that merely coordinates logistics? Design the opening 10 minutes of a team meeting that would actively build team cohesion.
- Many health managers say they 'don't have time' for team-building activities — they need to focus on delivering services. How would you respond to this? What is the opportunity cost of NOT investing in team development?

Session Summary — Key Takeaways

- A team is more than a group, it has shared goals, mutual accountability, complementary skills, and genuine collective commitment. The performance gap between an effective team and a group of individuals is enormous on complex tasks, like delivering health Program results
- Tuckman's five stages: Forming (director needed), Storming (coach needed), Norming (supporter needed), Performing (delegator needed), Adjourning (celebrator needed). Managers must continuously diagnose stage and adapt leadership style accordingly. Teams can regress under stress
- Belbin's nine team roles across three categories (Thinking: Plant, Monitor Evaluator, Specialist; Action: Shaper, Implementer, Completer-Finisher; People: Coordinator, Teamworker, Resource Investigator) — all nine are needed for high performance. Diagnose role gaps and imbalances to explain team dysfunctions
- Lencioni's five dysfunctions (bottom to top): Absence of Trust → Fear of Conflict → Lack of Commitment → Avoidance of Accountability → Inattention to Results. Each level is built on the one below — trust is the foundation of everything. Build psychological safety first
- Practical team-building tools: Team charter (shared agreements about purpose, roles, norms, accountability); effective meeting structures (daily stand-up, weekly review, monthly performance review, quarterly reflection); psychological safety (model vulnerability; respond to errors with curiosity; invite dissent)
- Diversity (different people in the room) + Inclusion (all voices genuinely heard and influential) = better decisions, more innovation, more equitable services. In Sudan's context: gender diversity in leadership; professional diversity; community representation. Diverse teams with low psychological safety produce neither equity nor performance

Suggested Reading:

1. Katzenbach JR & Smith DK (1993). The Wisdom of Teams. |
2. Tuckman BW (1965). Developmental Sequence in Small Groups. Psychological Bulletin. |
3. Belbin RM (1981). Management Teams: Why They Succeed or Fail. |
4. Lencioni P (2002). The Five Dysfunctions of a Team. |
5. Edmondson A (1999). Psychological Safety and Learning Behavior in Work Teams. Administrative Science Quarterly.

Management & Leadership of Health Programs | BSc Public Health

Session 9

Monitoring & Evaluation of Programs

M&E Frameworks, Indicator Development, Data Use for Decisions & Supervision Systems

Ahfad University for Women | Topic Two: Management Functions

Learning Outcomes — By the end of this session, students will be able to:

- Define monitoring and evaluation and explain the distinction between them and their complementary roles in Program management
- Describe the components of an M&E system and explain how they link to the Program LogFrame
- Develop Program indicators at each level of the results chain using the SMART criteria
- Explain the key methods of data collection used in health Program M&E and their relative strengths and limitations
- Describe supportive supervision as an M&E tool and distinguish it from punitive inspection
- Apply data to Program management decisions using a structured data review process

I. MONITORING VS. EVALUATION — COMPLEMENTARY FUNCTIONS

Monitoring and Evaluation (M&E) is the systematic process of tracking Program progress and assessing its effects. In health Program management, M&E serves one primary purpose: to generate information that enables better decisions for improved health outcomes. M&E data that is collected but not used is not M&E, it is data collection for compliance.

Dimension	MONITORING	EVALUATION
Definition	Continuous, routine tracking of Program implementation and outputs against the planned targets	Periodic, structured assessment of whether the Program achieved its outcomes and impact — and why
Timing	Ongoing throughout Program life — weekly, monthly, quarterly	At defined points: baseline (before), midterm (midway), endline (Program end)
Primary question	'Are we doing what we planned to do?' (implementation fidelity and output tracking)	'Did our Program make a difference?' (outcome and impact assessment)
Data sources	Routine Program data: registers, reports, supervision visits, stock records	Surveys, facility assessments, community interviews, focus group discussions, secondary data analysis
Who uses it	Program managers and implementers for real-time management decisions	Program managers, donors, policy-makers for strategic decisions and Program design
Output	Performance dashboard; monthly/quarterly reports; supervision reports	Baseline and endline survey reports; process evaluation; impact evaluation
Analogy	The dashboard of a car — tells you speed, fuel level, engine temperature right now	A mechanic's full service — tells you how the car has performed over time and what needs to change

Key Point: *The most common M&E failure in health Programs is not poor data collection — it is poor data use. Data is collected, compiled into reports, submitted to donors, and filed — without ever being used to improve Program performance. M&E must be designed backwards from the decisions it is meant to inform.*

II. THE M&E SYSTEM — COMPONENTS AND ARCHITECTURE

An M&E system is not just a set of data collection forms. It is an integrated architecture of components that together enable a Program to learn and adapt in real time:

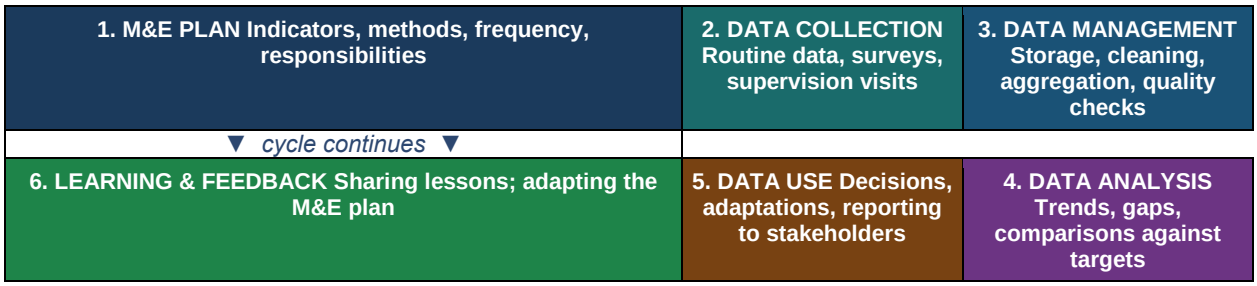
1. M&E PLAN Indicators, methods, frequency, responsibilities
2. DATA COLLECTION Routine data, surveys, supervision visits
3. DATA MANAGEMENT Storage, cleaning, aggregation, quality checks
▼ cycle continues ▼
6. LEARNING & FEEDBACK Sharing lessons; adapting the M&E plan
5. DATA USE Decisions, adaptations, reporting to stakeholders
4. DATA ANALYSIS Trends, gaps, comparisons against targets

Figure: The M&E System Cycle — six components that together enable data-driven Program management

M&E Component	Description	Common Failure Mode
M&E Plan	Documents all indicators, their definitions, targets, data sources, collection frequency, responsible persons, and reporting lines	Written once at project start, then ignored; not updated when Program changes; indicators are aspirational but not feasible to collect
Data Collection Tools	Registers, tally sheets, patient cards, mobile data collection forms, supervision checklists	Tools are too complex; not pretested; filled incorrectly because staff do not understand purpose; backlog of unfilled forms
Data Management System	Physical or digital system for storing, organizing, and aggregating data (HMIS, Excel, DHIS2, paper registers)	Data stored but never reviewed; paper data not transferred to summary tables; duplicate recording in multiple systems; no backup
Data Quality Assurance	Processes to verify data accuracy, completeness, and timeliness (spot checks, data verification visits, consistency checks)	Data quality is assumed not verified; inflated numbers to meet targets go unchallenged; '100% coverage' reported without triangulation
Data Analysis	Regular review of Program data against targets to identify gaps, trends, and underperforming areas	Analysis performed only for donor reports; percentages calculated but not interpreted; no comparison to baselines or benchmarks
Data Use for Decisions	Structured processes through which data findings are converted into management decisions and Program adaptations	Data presented in meetings but no decisions made; findings not acted upon; same poor-performing areas identified month after month without response

III. DEVELOPING PROGRAM INDICATORS

A. Types of Indicators

Indicators are the quantitative or qualitative measures that show whether Program objectives are being achieved. They must be selected carefully, bad indicators measure the wrong things, create perverse incentives, or are impossible to collect reliably:

Indicator Type	Definition	Health Program Example
Input indicators	Measure resources invested in the Program	Budget disbursed; staff trained; RUTF procured (kg); vehicles deployed
Process / Activity indicators	Measure whether activities are being implemented	Community meetings conducted; supervision visits completed; training sessions delivered
Output indicators	Measure direct products delivered by the Program	Children admitted to OTP; pregnant women receiving ANC; facilities with essential medicines
Outcome indicators	Measure changes in behaviour, knowledge, or service utilization attributable to the Program	% of births attended by skilled personnel; CMAM cure rate; % of mothers exclusively breastfeeding at 6 months
Impact indicators	Measure long-term changes in health status — the ultimate goal	Under-5 mortality rate; maternal mortality ratio; stunting prevalence; GAM prevalence
Coverage indicators	Measure what proportion of the target population is reached	CMAM treatment coverage (% of SAM cases receiving treatment); ANC coverage (% of pregnant women with 4+ visits)

B. The Indicator Reference Sheet

Every indicator in an M&E plan must have an indicator reference sheet, a detailed specification that ensures consistent measurement across the Program. A missing or incomplete indicator definition is a major quality risk:

Reference Sheet Element	Description	Example
Indicator name	Short, clear name	SAM treatment coverage rate
Definition	Precise description of what is measured, including numerator and denominator	Numerator: children 6-59 months admitted to OTP in the period. Denominator: estimated SAM caseload in the Program area. Expressed as %.
Data source	Where the data comes from	OTP admission register (Program data); caseload estimate from SMART survey or SAM estimation formula
Collection frequency	How often it is measured	Monthly (admissions); denominator updated annually from SMART survey
Baseline value	Value at Program start	22% (from SMART survey September 2024)
Target	Expected value at Program end	65% by December 2026
Responsible person	Who collects, compiles, and reports this indicator	District nutrition officer (compilation); facility nurse (data entry)
Disaggregation	Whether data should be broken down by sub-group	By sex (boys/girls); by facility; by locality

IV. DATA COLLECTION METHODS

Method	Description	Strengths	Limitations	Health Program Use
Routine Program data (HMIS, registers)	Data collected as part of normal Program delivery — facility registers, patient cards, tally sheets	Low additional cost; covers all service contacts; enables trend analysis over time	Data quality often poor; incomplete; subject to manipulation; delayed reporting	Primary source for output monitoring: admissions, coverage, attendance rates, commodity use
Structured observation	Observer watches and records specific practices or conditions against a checklist	Direct evidence of quality; not subject to recall or reporting bias	Observer effect (behaviour changes when watched); expensive (requires trained observer); time-intensive	Supervision quality checklists; clinical skills observation; facility readiness assessments
Individual interviews (KII)	In-depth conversations with key informants — health workers, managers, community leaders	Rich qualitative data; captures context and explanations; probes deeply	Small sample; not representative; subject to social desirability bias	Process evaluation; understanding barriers to service uptake; Program design
Focus Group Discussions (FGD)	Group discussion with 6-8 purposively selected participants	Group interaction generates richer data; efficient; community voices	Group dynamics may suppress individual views; not statistically representative	Community perceptions; barriers to care-seeking; IYCF practices; community feedback
Household surveys	Structured questionnaire administered to a random sample of households	Statistically representative; enables coverage calculation; comparable over time	Expensive and time-consuming; requires trained enumerators; sampling must be rigorous	Outcome measurement: coverage rates, nutritional status, knowledge and practice surveys
Facility assessments	Structured review of facility readiness, quality, and performance against standards	Standardized; comparable across facilities; identifies system gaps	Point-in-time snapshot; Hawthorne effect; quality varies by assessor	Health facility surveys; quality of care audits; EmONC signal function assessments

V. SUPPORTIVE SUPERVISION — M&E IN PRACTICE

A. Supportive vs. Punitive Supervision

Supervision is one of the most important M&E tools available to a health Program manager, and one of the most misunderstood. There is a fundamental difference between punitive inspection (which finds problems and punishes people) and supportive supervision (which finds problems and solves them together):

Dimension	Punitive Inspection	Supportive Supervision
Purpose	Find problems and assign blame	Identify gaps and support improvement together
Relationship	Inspector vs. inspected — adversarial	Coach and colleague — collaborative
Staff response	Hide problems; prepare only for the visit; anxiety and resentment	Report problems openly; look forward to visits as learning opportunity
Focus	Compliance with rules and procedures	Quality of service, staff development, problem-solving
Outcome	Short-term surface compliance; problems driven underground	Sustainable improvement; staff skill development; trust built
Data use	Data used to judge performance	Data used to understand and improve performance

B. The Supportive Supervision Visit — A Step-by-Step Guide

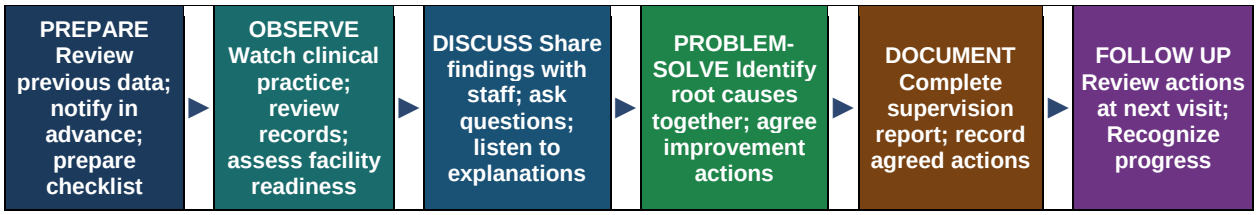
PREPARE Review previous data; notify in advance; prepare checklist
OBSERVE Watch clinical practice; review records; assess facility readiness
DISCUSS Share findings with staff; ask questions; listen to explanations
PROBLEM-SOLVE Identify root causes together; agree improvement actions
DOCUMENT Complete supervision report; record agreed actions
FOLLOW UP Review actions at next visit; Recognize progress

Figure: The Supportive Supervision Process — six steps from preparation to follow-up

Supervision Element	What to Include	Quality Indicator
Pre-visit preparation	Review previous supervision report and data; identify focus areas; prepare checklist; notify facility in advance	Supervisor arrives with data reviewed, specific questions prepared, and targeted checklist
Clinical/service quality observation	Observe a consultation or procedure; review patient records; check IPC practices; assess client communication	Uses validated checklist with specific criteria; observation is structured, not just walking around
Data and records review	Review facility register completeness; check tally sheets vs. summary reports; verify data quality	Spot-checks 10% of records; identifies discrepancies; discusses quality issues with data clerk
Staff interaction	Individual check-in with each staff member; assess knowledge and confidence; identify training needs	Uses open questions: 'What is going well?' 'What is making your work difficult?' 'What would help you most?'
Facility readiness	Check essential medicines, supplies, equipment, cold chain, water and sanitation	Uses standardised facility checklist; photographs evidence; identifies supply chain gaps
Feedback and action planning	Share findings with all staff collectively; agree 3-5 specific, time-bound improvement actions	Actions are written in supervision report; copy left with facility; followed up at next visit

VI. USING DATA FOR DECISIONS — THE DATA REVIEW PROCESS

Data collected by M&E systems only improves Program performance if it is regularly reviewed and acted upon. The data review meeting is the primary mechanism for converting M&E data into management decisions:

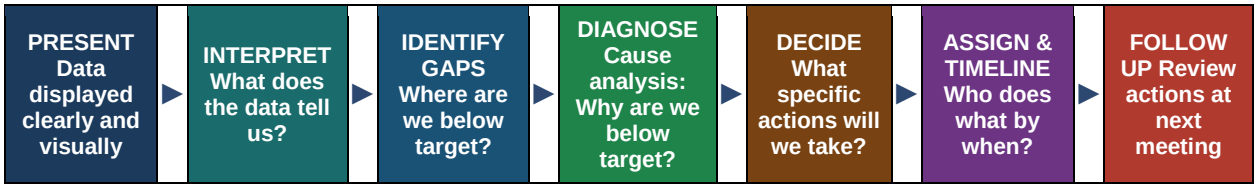
PRESENT Data displayed clearly and visually
INTERPRET What does the data tell us?
IDENTIFY GAPS Where are we below target?
DIAGNOSE Cause analysis: Why are we below target?
DECIDE What specific actions will we take?
ASSIGN & TIMELINE Who does what by when?
FOLLOW UP Review actions at next meeting

Figure: The Data Review and Decision-Making Process — seven steps from data presentation to follow-up action

The most common failure in data review meetings is stopping after step 3 (identifying gaps) without proceeding to steps 4-7 (cause diagnosis, decision, assignment, and follow-up). A meeting that identifies that coverage is 42% (below the 65% target) but produces no agreed action to address it is not a data review meeting, it is a reporting ceremony.

Data Use Principle	Description	Example
Triangulate data sources	Never rely on a single data source — cross-check with multiple sources to verify findings	Facility register shows 70% immunization coverage; community survey shows 52%. Investigate discrepancy before reporting either figure
Disaggregate data	Break data down by geography, sex, age group, or facility to identify which sub-populations are being missed	District average coverage 65% masks: urban facilities 82%, rural facilities 41% — the problem is entirely in rural areas
Compare to baseline and target	Data without a reference point is uninterpretable — always show trend over time and gap to target	Coverage 58% is not interpretable without knowing: baseline was 35% (good progress!) and target is 80% (still a gap)
Focus on outliers	High- and low-performing units provide the most learning	Which facility has 92% coverage? What are they doing differently? Which facility has 28%? What is blocking them?
Connect data to decisions	Every data review must end with named actions	'Coverage in Locality 4 is 31% — below all other localities. Action: district officer to conduct immediate supervisory visit and community mapping exercise. Responsible: Dr. Fatima. By: end of next week.'

VII. RESULTS-BASED MANAGEMENT — THE PERFORMANCE CULTURE

Results-Based Management (RBM) is a management approach that focuses all organizational attention on achieving defined, measurable results, not just completing activities. It represents a shift from 'compliance culture' (did we follow the rules?) to 'results culture' (did we make a difference?):

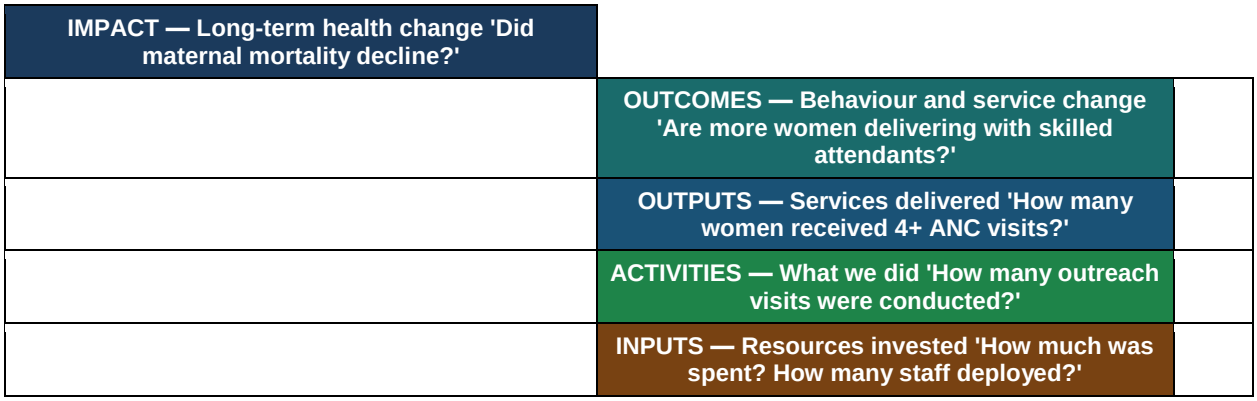
IMPACT — Long-term health change 'Did maternal mortality decline?'
OUTCOMES — Behaviour and service change 'Are more women delivering with skilled attendants?'
OUTPUTS — Services delivered 'How many women received 4+ ANC visits?'
ACTIVITIES — What we did 'How many outreach visits were conducted?'
INPUTS — Resources invested 'How much was spent? How many staff deployed?'

Figure: Results Chain — from inputs to impact; Results-Based Management focuses accountability on outcomes and impact, not just activities

Key Point: *The single most important shift in health Program management culture: moving accountability from inputs and activities ('we spent the budget and completed the activities') to outcomes and impact ('we improved the health of our target population'). Activity completion without outcome achievement is not success, it is expensive failure.*

Case Study: Data Use for Program Management — North Darfur Nutrition Program

- Background: A nutrition Program manager reviews her monthly data dashboard for 8 CMAM sites in North Darfur. Overall SAM admission rate: 412 children. Overall cure rate: 61% (below 75% Sphere standard). Default rate: 24% (above 15% standard). Coverage estimate: 38%.
- Data disaggregation reveals: When she breaks the data down by facility, she finds that 2 of the 8 sites account for 68% of all defaults (default rates of 41% and 38% respectively). The other 6 sites have default rates of 8-14%. The two high-default sites are both in localities bordering a conflict-affected area.
- Cause diagnosis: She visits both sites with her supervision checklist. Root causes identified: (1) Security incidents are preventing caregivers from making weekly return visits — they attend once, then cannot return. (2) RUTF stockout at one site lasted 3 weeks last month — children were admitted but could not receive treatment. (3) Community health volunteers in both localities are not conducting follow-up home visits for defaulters.
- Data-driven decisions: (1) Negotiate with NGO partner to introduce RUTF take-home packs (monthly supply given at admission) to reduce visit frequency for security-affected families. (2) Fix supply chain — identify root cause of stockout and address. (3) Train and supervise CHVs on defaulter tracing protocols.
- Discussion: What data disaggregation was most important in this case? Which of the seven data use principles were applied? What would have happened if the manager had only reviewed the district average without disaggregating?

Practical Activity: M&E Plan Development Exercise

- Scenario: You are designing an M&E plan for a 2-year community WASH (Water, Sanitation and Hygiene) Program aiming to reduce diarrhoeal disease in a district of 50,000 people through: construction of 200 latrines; training 100 hygiene promoters; community behaviour change on handwashing; and safe water treatment at household level.
- Task 1 — Indicators: Identify one SMART indicator for each level: Impact, Outcome, Output (for two outputs), and Process. For each indicator, complete the indicator reference sheet (name, definition, baseline, target, data source, frequency, responsible person).
- Task 2 — Data collection methods: For each of your five indicators, identify the most appropriate data collection method. Justify your choices.
- Task 3 — Supervision plan: Design a supportive supervision schedule for the 100 hygiene promoters. How often? By whom? Using what checklist elements? How will findings be used?
- Task 4 — Data review meeting: Design a monthly data review meeting agenda for this Program. Who attends? What data is reviewed? How long does it run? What decisions are expected to come out of it?

Reflection / Discussion Questions

- The session argues that M&E data collected but not used is 'data collection for compliance.' In your experience or observation, what proportion of health Program data in Sudan is actually used to make management decisions — and what proportion is collected only to satisfy donor reporting requirements? What systemic factors drive this?
- Supportive supervision is described as a collaborative, coaching-oriented practice. Yet in Sudan's health system, supervision is often experienced by health workers as inspection, judgment, or harassment. What specific management behaviours distinguish supportive from punitive supervision — and what would it take to shift the culture in a health facility you know?
- Results-Based Management shifts accountability from activities to outcomes. Critics argue that this places unfair accountability on Program managers for outcomes that are shaped by factors outside their control (conflict, drought, inflation). How would you design an accountability system that is fair and realistic while still maintaining genuine focus on health impact?

Session Summary — Key Takeaways

- Monitoring (continuous, tracks implementation against plan) and Evaluation (periodic, assesses outcome and impact) are complementary — both essential. The primary purpose of both is to inform better management decisions, not to report to donors. Data not used for decisions is compliance reporting, not M&E.
- M&E system components: M&E Plan → Data Collection → Data Management → Data Analysis → Data Use → Learning and Feedback. Common failures occur at the data use step — data is collected and compiled but never converted into management decisions.
- Indicator types: Input, Process/Activity, Output, Outcome, Impact, Coverage. Every indicator requires a reference sheet: name, definition (with numerator/denominator), data source, frequency, baseline, target, responsible person, disaggregation. SMART criteria apply to all indicators.
- Data collection methods: routine Program data (low cost, wide coverage, quality risks), structured observation (direct evidence, expensive), interviews and FGDs (qualitative depth),

household surveys (representative, costly), facility assessments (standardized, point-in-time). No single method is sufficient — triangulation is essential.
• Supportive supervision: collaborative, coaching-oriented, builds trust and skills. NOT punitive inspection. Six steps: Prepare → Observe → Discuss → Problem-Solve → Document → Follow Up. Supervision is the manager's primary real-time M&E tool and the most direct investment in service quality.
• Data review process: Present → Interpret → Identify Gaps → Diagnose Causes → Decide → Assign & Timeline → Follow Up. Disaggregate data to reveal sub-group differences; compare to baseline and target; focus on outliers; always end with named, time-bound actions. Results-Based Management: accountability for outcomes and impact, not just activity completion.

Suggested Reading:

1. UNDP (2009). Handbook on Planning, Monitoring and Evaluating for Development Results. |
2. WHO (2011). Monitoring the building blocks of health systems. |
3. MSH (2008). Managers Who Lead — Chapter 8. |
4. MEASURE Evaluation (2013). Monitoring and Evaluation Systems Strengthening Tool. |
5. WHO (2015). Global Standards for Quality Health Services.

Management & Leadership of Health Programs | BSc Public Health

Session 12

The Strategic Leader

Building Coalitions, Networks & Alliances — The Political and Relational Dimensions of Health Leadership

Ahfad University for Women | Topic Three: Leadership Theories & Types

Learning Outcomes — By the end of this session, students will be able to:

- Define strategic leadership and explain why it differs from operational management and Program leadership
- Describe the concept of power in organizations — its sources, types, and ethical use in health leadership
- Explain what coalitions are, why they matter in health, and how to build them effectively
- Describe the principles of stakeholder mapping and political analysis for strategic leaders
- Apply networking skills to build the external relationships needed for Program sustainability and influence
- Describe the characteristics and strategies of strategic alliances in health systems and explain how to manage them

I. WHAT IS STRATEGIC LEADERSHIP?

Strategic leadership is the ability to anticipate, envision, maintain flexibility, think strategically, and work with others to initiate changes that will create a viable future for the organization. It operates at the intersection of leadership (inspiring people) and strategy (setting direction), and it requires a specific set of competencies that go beyond Program management.

Strategic leaders in health do not simply manage their Programs well, they shape the environment in which their Programs operate. They influence policy, mobilize resources, build alliances, navigate political dynamics, and position their organizations for long-term impact. In Sudan's health system, where resources are scarce, politics matter enormously, and sustainable change requires broad coalitions, strategic leadership is not optional, it is essential.

Dimension	Operational Program Leader	Strategic Leader
Time horizon	Current Program cycle (1-2 years)	3-10 years — anticipates future challenges before they arrive
Focus	Delivering Program activities and outputs	Shaping the environment, policy, and resources that enable Programs
Key relationships	Team, direct beneficiaries, immediate partners	Government, donors, civil society, media, regional and global networks
Primary question	'Are we implementing the plan?'	'Are we in the right position to create lasting impact?'
Challenge type	Technical and operational — known problems with known solutions	Adaptive — novel problems requiring new thinking, coalition building, and change management
Risk orientation	Manages known risks within the Program	Identifies emerging threats and opportunities before others; takes calculated risks

II. POWER — THE CURRENCY OF STRATEGIC LEADERSHIP

A. Sources of Power

Power is the capacity to influence others' behaviour and decisions. Strategic leaders understand power not as a personal possession to be hoarded, but as a resource to be cultivated and used in service of the mission. French and Raven (1959) identified five classic power bases, plus two additional forms critical for health leadership:

Power Source	Definition	Health Leadership Application	Sustainability
Legitimate (Position) Power	Authority derived from formal role and title	District Health Officer authority to direct staff and allocate resources	Lasts only while the role is held; creates compliance but not commitment
Expert Power	Influence derived from knowledge, skill, and expertise	A nutritionist whose technical knowledge is Recognized and trusted by peers and government	Grows over time; endures beyond role changes; creates genuine respect
Referent Power	Influence derived from personal qualities — charisma, integrity, values — that others want to emulate	A Program director whom staff follow because of who she is, not just because of her title	Most powerful and most durable; cannot be given or taken by an organization
Reward Power	Ability to provide things others value — promotion, recognition, resources	Manager who controls access to training opportunities, performance bonuses, and project assignments	Dependent on continued access to rewards; creates transactional, not transformational, relationships
Coercive Power	Ability to impose negative consequences — demotion, criticism, withholding resources	Using threat of disciplinary action to ensure compliance	Produces compliance through fear; destroys trust; deeply counterproductive in health settings
Information Power	Control over access to information that others need	Health manager who is the primary conduit between field teams and the Ministry of Health	Temporary — information flows eventually equalise; creates dependency rather than trust
Connection Power	Influence derived from relationships with other powerful actors	Program manager whose relationship with the State Minister enables resource access others cannot achieve	Grows with investment; requires ethical management; becomes social capital for the organization

Key Point: *Strategic leaders deliberately cultivate expert, referent, and connection power — the three most sustainable and ethical forms. They use legitimate and reward power judiciously as tools, never as ends in themselves. They avoid coercive power: it destroys the psychological safety and trust that high-performing health systems require.*

III. BUILDING COALITIONS

A. What Is a Coalition and Why Does It Matter?

A coalition is a temporary alliance of individuals or organizations who combine their resources and influence to achieve a shared goal that none could achieve alone. In health, coalitions are the primary mechanism through which change actually happens, individual organizations, however excellent, rarely have the resources, legitimacy, or political reach to change policies, shift funding flows, or transform population health outcomes on their own.

WHY COALITIONS MATTER IN HEALTH LEADERSHIP
RESOURCES
• Pool funding from multiple donors
• Share human resources and expertise
• Reduce duplication of infrastructure
• Joint procurement reduces costs
LEGITIMACY & VOICE
• Coalition speaks with one voice to government
• Community trusts broad coalition more than single actor
• Harder for opposition to dismiss or marginalize
• Collective credibility opens doors
SCALE & COVERAGE
• Reach populations no single organization can cover
• Combine geographic coverage across partners
• Deliver comprehensive service packages
• Sustained presence through partner complementarity
POLITICAL INFLUENCE
• Coalition can advocate collectively for policy change
• Multiple stakeholders create political accountability
• Shared data amplifies the evidence base
• Protects individual organizations from political risk

Figure: Four reasons coalitions are essential for health leadership — resources, legitimacy, scale, and political influence

B. Building a Coalition — The Seven Steps

STEP 1 IDENTIFY THE SHARED GOAL: Define the change you want to achieve precisely enough that potential partners can assess their interest. Vague goals attract no one; a clear, compelling problem statement attracts allies.

▼

STEP 2 MAP POTENTIAL COALITION MEMBERS: Use stakeholder analysis (Session 4) to identify who shares this goal, who has complementary resources, and who has the influence needed. Include unlikely allies — private sector, religious leaders, women's groups.

▼

STEP 3 ASSESS INTERESTS AND MOTIVATIONS: For each potential member, understand what they will gain from joining — not just what you need from them. Coalition building is built on mutual benefit, not unilateral extraction.

▼

STEP 4 ESTABLISH GOVERNANCE: Agree how decisions will be made, how resources will be managed, who speaks publicly for the coalition, and how disagreements will be resolved. Weak governance destroys coalitions faster than external opposition.

▼

STEP 5 BUILD TRUST THROUGH EARLY WINS: Identify a quick, achievable collective action that demonstrates the coalition can function. Early success generates momentum and commitment before the harder, longer work begins.

▼

STEP 6 **MAINTAIN AND SUSTAIN: Coalitions require ongoing investment — regular communication, shared learning, recognition of each member's contribution. Coalitions that form only around a crisis dissolve when the crisis passes.**

▼

STEP 7 **MANAGE CONFLICT AND FREE-RIDERS: Address disagreements quickly using the collaborative approach (Session 7); address members who take resources without contributing — clearly and early — before resentment fragments the coalition.**

Figure: Building a Coalition — seven steps from goal identification to long-term sustainability

IV. STAKEHOLDER MAPPING AND POLITICAL ANALYSIS

A. Beyond Stakeholder Management — Political Analysis

Program managers do stakeholder analysis to understand who is involved and how to engage them. Strategic leaders go further, they conduct political analysis to understand how power, interests, and alliances actually shape decisions in their environment. This is not about being 'political' in a manipulative sense, it is about understanding the real dynamics so you can navigate them ethically and effectively.

Political Analysis Tool	Purpose	How to Apply
Power Mapping	Identify who has the power to enable or block the change you want to achieve	List all key actors; assess their power (formal and informal); mark their current position (support/oppose); identify who influences whom
Influence Network Mapping	Understand who influences the key decision-makers — even if not directly involved	Map the relationships between key actors; identify informal advisors and gatekeepers; note family, tribal, and professional networks
Interest Analysis	Understand what each actor stands to gain or lose from the proposed change	For each actor: what is their primary interest? How does this change affect it? What would make them a champion rather than a blocker?
Alliance Mapping	Identify existing alliances and potential new ones	Which actors already work together? Which have shared interests but no current relationship? What alliances could be built to shift the political balance?
Change Readiness Assessment	Assess how ready the environment is for the proposed change	Is there a political window opening? Is there a crisis that creates opportunity for change? Who is the champion with most to gain? What is the tipping point?

Example: *A nutrition Program director wants to secure government budget line funding for CMAM — currently entirely donor-dependent. Political analysis reveals: the State Minister of Health is personally committed to reducing child mortality (potential champion); the Director of Finance has concerns about long-term fiscal sustainability (potential blocker); a prominent community leader in the most affected district is trusted by both (potential bridge); a neighboring state that successfully secured CMAM budget funding provides a powerful precedent. Strategic action: brief the community leader; arrange a cross-state learning visit for the Finance Director; frame the ask as 'reducing donor dependency' rather than 'adding spending'.*

V. NETWORKING — BUILDING THE STRATEGIC LEADER'S SOCIAL CAPITAL

A. Three Types of Networks

Strategic leaders invest deliberately in three distinct types of networks, each serving a different purpose:

Network Type	Purpose	Who It Includes	Investment Required
OPERATIONAL NETWORK (Internal)	Get the day-to-day work done; maintain functional relationships needed for current role	Direct team; colleagues in the same organization; key internal service providers (finance, HR, logistics)	Maintain continuously; primary focus of most managers; relatively low deliberate investment — relationships form naturally through work
PERSONAL NETWORK (External — professional)	Career development; personal learning; peer support; future opportunities	Professional peers in similar roles; mentors; alumni of training Programs; professional association members	Invest time outside work; attend professional events; contribute to professional communities; maintain even when not immediately needed
STRATEGIC NETWORK (External — political and sectoral)	Shape the environment; access information before others; build coalitions; influence policy	Government officials; donors; civil society leaders; academic institutions; media; regional and global networks	Most strategic value; requires the most deliberate cultivation; neglected by most Program managers — their primary differentiator for strategic leaders

Most health Program managers invest almost exclusively in their operational network. Strategic leaders deliberately invest in all three — particularly the strategic network, which has the highest leverage for organizational impact but requires the most intentional cultivation.

B. Networking Principles and Practices

Principle	Description	Practical Application
Give before you take	Effective networks are built on reciprocity — lead by offering value before seeking it	Share useful information; make introductions; offer support without expectation of immediate return; be generous with your expertise
Stay in contact consistently	Networks atrophy without maintenance — relationships go cold if contact is only when you need something	Brief check-in messages; sharing relevant articles; congratulating on achievements; attending events; periodic coffee meetings
Be genuinely curious	People can tell when networking is transactional — genuine interest in others is both ethically right and strategically superior	Ask about their work challenges and learning; follow up on previous conversations; remember personal details
Span structural holes	The most valuable network positions connect otherwise disconnected groups — bridging social capital is more powerful than bonding social capital	Deliberately connect people from different sectors, organizations, and disciplines; become a hub that links others
Document and manage your network	Informal networks are forgotten without a system	Maintain a simple contact database; note last contact, their interests, and how you might add value; schedule regular outreach

VI. STRATEGIC ALLIANCES IN HEALTH

A. Types of Alliances

A strategic alliance is a formal, sustained relationship between two or more organizations who agree to cooperate to achieve mutually beneficial goals while remaining independent. Unlike coalitions (usually issue-focused and time-limited), strategic alliances are typically longer-term structural relationships:

Alliance Type	Description	Health Example	Key Success Factor
Referral partnership	Formal agreement to refer clients between organizations for complementary services	Hospital and community health Program agree on two-way referral protocols with shared patient records	Clear referral criteria; feedback loops; shared data systems; joint protocol review
Joint programming	Two or more organizations co-design and co-implement a Program with defined roles	UN agency and NGO co-implement a maternal health Program — NGO delivers community component; UN provides technical support and donor liaison	Clear role delineation; shared governance; joint M&E; trust built through previous collaboration
Resource-sharing alliance	Formal agreement to share human resources, facilities, or equipment to reduce costs and increase efficiency	Two NGOs share a cold chain vehicle, warehouse space, and logistics officer in a remote district	Detailed cost-sharing agreement; conflict resolution mechanism; shared maintenance responsibility
Advocacy alliance	Coalition focused specifically on influencing policy, funding, or public awareness	Network of nutrition organizations that jointly advocacy for increased government allocation to community nutrition	Agreed policy positions; shared communications strategy; clear decision-making process; managing member diversity
Learning alliance	Formal structure for sharing learning, innovations, and evidence across organizations	Government + academic institution + NGOs collaborate to test and scale a new community health worker model	Committed to sharing failures as well as successes; trust and psychological safety across organizational boundaries

B. Managing Strategic Alliances — Key Principles

- Formalize the relationship: A written Memorandum of Understanding (MoU) or partnership agreement clarifies roles, responsibilities, resources, governance, and exit arrangements before problems arise
- Establish joint governance: Regular joint leadership meetings with shared agenda; clear decision-making authority; escalation pathway for disputes
- Build personal relationships at multiple levels: Alliance strength depends not only on senior leadership relationships, it must be embedded at field level too
- Share information generously: Alliances fail when partners hoard information to protect competitive advantage; strategic sharing builds trust and collective effectiveness
- Manage the power asymmetry: When a large international organization allies with a small local NGO, power differences can undermine the partnership; the stronger partner must actively compensate
- Conduct regular alliance health reviews: Annually assess the alliance against agreed criteria — is it still adding value? Are roles still appropriate? Is trust maintained?

Case Study: Strategic Leadership in Action — Building the Kordofan Nutrition Coalition

- Background: Dr. Fatima is the State Nutrition Coordinator for North Kordofan. Acute malnutrition rates have remained stubbornly high despite 5 years of programming. The core problem: 14 different organizations are running fragmented nutrition activities with different protocols, competing for the same donor funds, and reaching only 31% coverage of SAM children. There is no coordination mechanism, no shared data, and considerable inter-agency rivalry.
- Power analysis: Fatima conducts a political analysis. She identifies: the State Minister of Health as a potential champion (motivated by a recent high-profile child death); the UN agency as the largest donor with the most convening power but no direct implementation; three NGOs as implementers with good field reach but competing for the same funding; the academic nutrition faculty as a neutral party with technical credibility; communities as the ultimate voice of accountability.
- Coalition building: She proposes to the UN agency (leveraging their convening power) a State Nutrition Coordination Forum. Key design decisions: hosted by the Ministry of Health (not the UN) to establish government ownership; technical secretariat provided by the academic faculty (neutral); decision-making by consensus with explicit escalation to Ministry if consensus fails; all agencies agree to use a single SAM caseload estimate (ending the competing numbers problem).
- Early win: First joint action — a shared RUTF pre-positioning exercise before the lean season that reduces stockouts across all sites by 60%. This tangible collective benefit builds coalition confidence and demonstrates the value of cooperation over competition.
- Alliance with academic institution: Fatima formalizes a learning alliance with the nutrition department to conduct an annual state-level SMART survey. The alliance provides the Ministry with independent, credible coverage data — used for both donor reporting and budget advocacy.
- Discussion: Which sources of power did Fatima use? How did she navigate the tension between competing organizations? What governance decisions were most critical to the coalition's early success? What threats could still undermine this coalition?

Practical Activity: Coalition Mapping Exercise

- Scenario: You are a Program manager seeking to reduce early childhood marriage in a rural district in Sudan by strengthening girls' education and community norms change. This requires engaging government (education and health), religious leaders, community elders, girls' schools, women's groups, and media. Some of these actors are currently opposed to the goal.
- Task 1 — Power Map: List 8-10 potential coalition members. For each, rate their power (H/M/L) and their current position (Champion/Ally/Neutral/Critic/Blocker). Draw the influence relationships between them.
- Task 2 — Interest Analysis: For each actor, identify their primary interest and what would motivate them to join or support the coalition.
- Task 3 — Coalition Structure: Design the coalition governance: What is the name and mandate? Who chairs it? How are decisions made? How often does it meet? What is the first early-win action?
- Task 4 — Risk Analysis: Identify three risks that could undermine this coalition. For each, propose a mitigation strategy.

Reflection / Discussion Questions

- The session argues that strategic leaders must understand and navigate power dynamics — including political, tribal, and institutional power structures. Some health professionals find this uncomfortable, feeling that 'getting political' compromises professional integrity. How do you reconcile the need for political navigation with the values of equity and evidence-based practice?
- Coalition building requires giving up some autonomy and visibility to achieve collective impact. What are the main reasons health organizations resist joining or sustaining coalitions? How can a strategic leader address these resistances — both in their own organization and in potential partners?
- Networking is described as a professional and strategic investment. But in Sudan, personal relationships often intersect with family, tribal, and political affiliations in ways that create both opportunities and ethical tensions. How does a strategic health leader build and use networks ethically — ensuring that connection power is used in service of health equity, not personal or factional advantage?

Session Summary — Key Takeaways

- Strategic leadership operates beyond Program management — it shapes the environment, policy, and resources that enable Programs. Strategic leaders anticipate change, build alliances, navigate power, and position their organizations for long-term impact. In Sudan's health context, strategic leadership competency is essential for sustainable health improvement.
- Power has seven sources: Legitimate (position), Expert (knowledge), Referent (personal qualities), Reward (providing valued things), Coercive (imposing consequences), Information (controlling access), and Connection (relationships with powerful others). Strategic leaders cultivate Expert, Referent, and Connection power — the most sustainable and ethical forms.
- Coalitions pool resources, legitimacy, scale, and political influence that no single organization possesses alone. Seven steps: identify shared goal → map potential members → assess interests → establish governance → achieve early wins → maintain and sustain → manage conflict and free-riders. Governance quality is the primary predictor of coalition success.
- Political analysis tools: Power Mapping (who can enable or block change), Influence Network Mapping (who influences decision-makers), Interest Analysis (what each actor stands to gain or lose), Alliance Mapping (existing and potential partnerships), Change Readiness Assessment (is the political window open?). Political navigation is not manipulation — it is understanding real dynamics to achieve health equity goals.
- Three network types: Operational (internal — daily work), Personal (external — career and learning), Strategic (external — environment shaping and influence). Most managers invest only in operational networks; strategic leaders deliberately cultivate all three, especially the strategic network. Networking principles: give before taking; stay in contact; be genuinely curious; span structural holes.
- Strategic alliances: referral partnerships, joint programming, resource-sharing, advocacy, and learning alliances. Key management principles: formalize with MoU; establish joint governance; build relationships at multiple levels; share information generously; manage power asymmetries; conduct annual alliance health reviews.

Suggested Reading:

1. Kotter JP (1996). Leading Change — Chapter 4: Building the Guiding Coalition. |
2. French JRP & Raven B (1959). The bases of social power. In D. Cartwright (Ed.), Studies in Social Power. |
3. Buse K, Mays N & Walt G (2005). Making Health Policy — Chapter 3. |
4. MSH (2008). Managers Who Lead — Chapter 9: Building Alliances. | Gladwell M (2000). The Tipping Point — Chapter 2: The Law of the Few.

Management & Leadership of Health Programs | BSc Public Health

Session 14

The Transformational Leader

Leading Evidence-Based Decision Making — Course Synthesis & Personal Leadership Commitment

Ahfad University for Women | Topic Three: Leadership Theories & Types | Final Session

Learning Outcomes — By the end of this session, students will be able to:

- Define evidence-based decision making and explain why it is the hallmark of a transformational health leader
- Describe the hierarchy of evidence and apply it to leadership decisions in health Program management
- Explain the barriers to evidence use in health leadership and apply strategies to overcome them
- Integrate the course learning by applying management and leadership frameworks to a complex, realistic case
- Articulate a personal leadership philosophy connecting course learning to individual values, context, and ambition
- Commit to specific personal development priorities for continued growth as a health Program leader

I. TRANSFORMATIONAL LEADERSHIP REVISITED — THE EVIDENCE DIMENSION

Session 11 introduced transformational leadership through the lens of the Four I's: Idealized Influence, Inspirational Motivation, Intellectual Stimulation, and Individualized Consideration. This final session focuses on the fourth dimension, Intellectual Stimulation, as the foundation of transformational leadership in health: the commitment to evidence-based decision making.

A transformational leader who inspires without evidence is a charismatic storyteller. A transformational leader who uses evidence without inspiration is an analyst. The combination, vision grounded in evidence, communicated with passion, pursued through disciplined measurement, is the hallmark of the complete health leader.

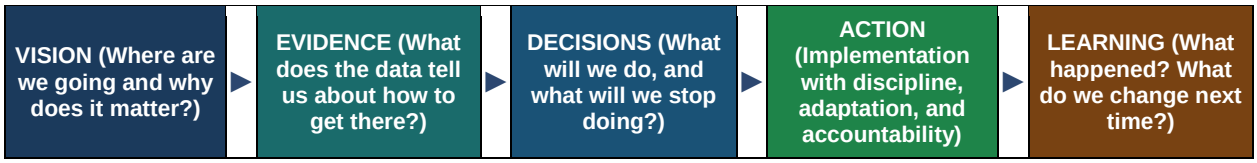
VISION (Where are we going and why does it matter?)
EVIDENCE (What does the data tell us about how to get there?)
DECISIONS (What will we do, and what will we stop doing?)
ACTION (Implementation with discipline, adaptation, and accountability)
LEARNING (What happened? What do we change next time?)

Figure: The Transformational Evidence-Based Leadership Cycle — vision and evidence are inseparable for the complete health leader

II. EVIDENCE-BASED DECISION MAKING

A. What Is Evidence-Based Decision Making?

Evidence-based decision making (EBDM) is the practice of making decisions by integrating the best available evidence with professional expertise, stakeholder values, and contextual knowledge. It was developed in medicine (evidence-based medicine, Sackett et al., 1996) and has been extended to management, policy, and leadership.

EBDM does not mean 'only randomized controlled trials can inform decisions.' It means using the best available evidence for the question at hand, combining quantitative data, qualitative insights, implementation experience, and ethical judgement, rather than relying on intuition, habit, authority, or anecdote alone.

Decision Basis	Description	Risk	Health Example
Intuition / gut feeling	Decision based on instinctive judgement without conscious reasoning	High — subject to cognitive biases (Session 2); ignores available evidence	Choosing a community health worker training approach because 'it feels right' without reviewing evidence on effective CHW models
Authority / precedent	'We do it this way because we always have' or 'The director said so'	High — perpetuates ineffective practices; disconnects decisions from outcomes	Continuing paper-based data collection because 'that is what we use' despite availability of better mobile tools
Anecdote / single case	Basing Program-wide decisions on one memorable story or personal experience	High — availability heuristic (Session 2); single cases are not representative	Abandoning a proven intervention because one community health worker had a bad experience with it
Evidence-based	Integrating best available research evidence + Program data + professional expertise + stakeholder values	Appropriate — acknowledges uncertainty; tests assumptions; improves over time	Selecting CMAM protocols based on Sphere standards, WHO guidelines, local SMART survey data, and community feedback on acceptability

B. The Hierarchy of Evidence

Not all evidence is equally reliable. The evidence hierarchy ranks study designs by their resistance to bias — from the most rigorous (systematic reviews of multiple trials) to the weakest (expert opinion or single anecdotes). Leaders should use the best available evidence while acknowledging its limitations:

Evidence Level	Study Type	Reliability	Health Program Use
Level 1 — Highest	Systematic reviews and meta-analyses of multiple RCTs	Strongest — aggregates evidence across multiple studies; corrects for individual study weaknesses	Choosing the recommended SAM treatment protocol based on Cochrane systematic review of CMAM evidence
Level 2	Randomized Controlled Trials (RCTs)	Strong for establishing causation — random assignment controls for confounders	Evaluating whether a new community mobilization approach improves immunization rates vs. the standard approach
Level 3	Non-randomized controlled studies; cohort studies	Moderate — demonstrates association but causation requires careful interpretation	Program evaluation comparing outcomes in districts with and without a supervision intervention
Level 4	Case-control studies; cross-sectional surveys	Useful for prevalence, associations, and hypothesis generation	SMART survey providing district GAM prevalence; KAP survey on maternal health knowledge
Level 5	Program monitoring data; routine HMIS	Context-specific and timely — essential for operational decisions	Monthly coverage data showing which facilities are below target; defaulter tracking data
Level 6 — Lowest	Expert opinion; clinical experience; anecdote	Weakest but often the only evidence available for local operational questions	Experienced field supervisor's judgement that security conditions in a locality are too unsafe for outreach this week

Key Point: *The evidence hierarchy is a guide to reliability — not a prescription for paralysis. When Level 1 evidence exists, use it. When it does not, use the best available evidence at the level that exists — while being explicit about its limitations. A decision made with Level 5 evidence, acknowledged as such, is better than a decision made with no evidence or undisclosed intuition.*

III. BARRIERS TO EVIDENCE USE — AND HOW TO OVERCOME THEM

Barrier	Description	Transformational Leader's Response
Evidence is not available	Relevant local data does not exist; global evidence does not apply to local context	Commission context-specific assessments (SMART surveys, KAP surveys, bottleneck analyses); build routine data systems that generate usable local evidence; contribute to research partnerships with academic institutions
Evidence is not accessible	Research is behind paywalls; reports are in English; data is held by another organization and not shared	Advocate for open access; maintain relationships with academic partners who can translate research; negotiate data-sharing agreements; use WHO and Cochrane free resources
Evidence is not understood	Data is available but leaders lack skills to interpret it; complex statistics presented without explanation	Invest in analytical capacity development; use visual data presentations; partner with technical experts for data interpretation; use structured data review processes (Session 9)
Evidence is not trusted	Decision-makers distrust external evidence as 'not applicable here'; distrust Program data due to known quality issues	Address data quality systematically (Session 9); triangulate multiple sources; generate local pilot evidence; build a culture where data is used to improve, not to punish
Evidence conflicts with authority or tradition	Senior decision-makers prefer to act on precedent, authority, or personal experience; challenging this creates political risk	Build evidence culture from within; frame evidence as supporting (not threatening) leadership; use champions in authority positions; document cases where evidence improved outcomes
No time for evidence	Under time pressure, intuition feels faster than systematic evidence review	Build evidence use into routine processes (work plans, meeting agendas, supervision visits); use rapid appraisal methods; accept 'good enough' evidence for operational decisions vs. requiring Level 1 evidence for everything

IV. THE TRANSFORMATIONAL LEADER AS A LEARNING LEADER

A. The Learning Organization

Peter Senge (1990) argued that the organizations that will thrive in a complex, changing world are those that can learn faster than the rate of change. A learning organization is one where people continuously expand their capacity to create the results they truly desire, where collective aspiration is set free, and where people are continually learning how to learn together.

The transformational health leader creates the conditions for organizational learning, not just personal learning. This requires specific leadership behaviour:

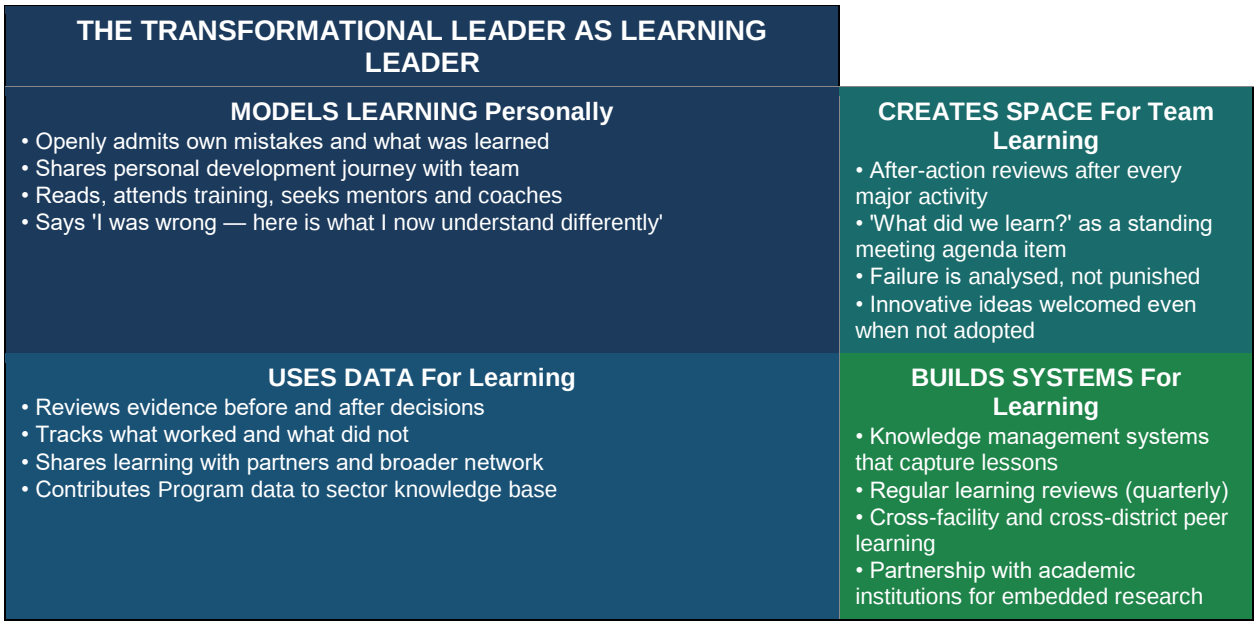
THE TRANSFORMATIONAL LEADER AS LEARNING LEADER
MODELS LEARNING Personally
• Openly admits own mistakes and what was learned
• Shares personal development journey with team
• Reads, attends training, seeks mentors and coaches
• Says 'I was wrong — here is what I now understand differently'
CREATES SPACE For Team Learning
• After-action reviews after every major activity
• 'What did we learn?' as a standing meeting agenda item
• Failure is analysed, not punished
• Innovative ideas welcomed even when not adopted
USES DATA For Learning
• Reviews evidence before and after decisions
• Tracks what worked and what did not
• Shares learning with partners and broader network
• Contributes Program data to sector knowledge base
BUILDS SYSTEMS For Learning
• Knowledge management systems that capture lessons
• Regular learning reviews (quarterly)
• Cross-facility and cross-district peer learning
• Partnership with academic institutions for embedded research

Figure: Four dimensions of the Transformational Leader as Learning Leader

B. After-Action Review — The Core Learning Practice

The After-Action Review (AAR) — originally developed by the US Army is the most practical team learning tool available. It asks four questions after any significant activity, event, or Program cycle:

AAR Question	What It Explores	Facilitation Tip
1. What did we intend to happen?	The plan — what were the goals, activities, and expected results?	Refer back to the work plan; ensure everyone has the same baseline understanding
2. What actually happened?	The reality — what were the actual results (using data where possible)?	Use objective data first, then add observations; avoid blame; separate facts from interpretations
3. Why was there a difference?	The analysis — what caused the gap between intention and reality?	Go deep: ask 'why?' multiple times; distinguish root causes from symptoms; avoid stopping at the first explanation
4. What will we do differently next time?	The learning — specific, actionable commitments to change	Document agreed actions; assign responsibility; build into next planning cycle; follow up at next AAR

Key Point: *The AAR is only effective in a psychologically safe environment (Session 8). In a low-trust, punitive culture, staff will give safe answers at AARs rather than honest ones. Creating the conditions for honest learning is itself a transformational leadership task — it requires consistent demonstration that raising problems leads to solutions, not punishment.*

V. INTEGRATING THE COURSE — THE COMPLETE HEALTH LEADER

This course has covered three interconnected topics: the concepts and functions of management, the practical functions of health Program management, and the theories and types of leadership. In this final section, we synthesize these into an integrated picture of what it means to be a complete health Program leader in Sudan's context.

Course Topic	Key Sessions	Core Competency Developed
TOPIC 1: Management & Leadership (Sessions 1-3)	Session 1: Management concepts & the POLC cycle Session 2: Decision-making Session 3: Manager vs. leader & styles	Understanding the foundations: what management and leadership are, how decisions are made, and how style must adapt to situation and person
TOPIC 2: Management Functions (Sessions 4-9)	Session 4: Program design (LogFrame, ToC) Session 5: Strategic planning Session 6: Time management Session 7: Human resources & conflict Session 8: Team building Session 9: Monitoring & evaluation	The practical management toolkit: designing Programs, planning strategically, using time well, managing people, building teams, and measuring what matters
TOPIC 3: Leadership Theories & Types (Sessions 11-14)	Session 11: Leadership theories overview Session 12: Strategic leader (coalitions, power, networks) Session 13: Visionary leader (vision, mission, goals, change) Session 14: Transformational leader (evidence-based decisions, learning)	The leadership dimension: understanding how leadership theory has evolved, building strategic relationships, inspiring through vision, and leading with evidence and continuous learning

The complete health leader holds all three dimensions simultaneously — managing effectively (delivering results through systems and processes), leading people (inspiring, developing, and empowering others), and leading strategically (shaping the environment, building coalitions, and anchoring decisions in evidence). No single dimension is sufficient:

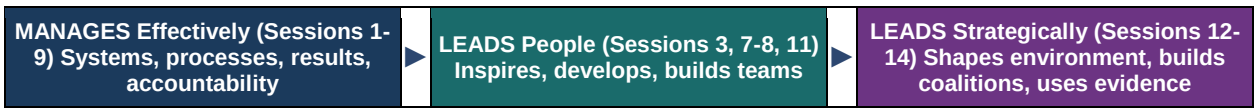
MANAGES Effectively (Sessions 1-9) Systems, processes, results, accountability
LEADS People (Sessions 3, 7-8, 11) Inspires, develops, builds teams
LEADS Strategically (Sessions 12-14) Shapes environment, builds coalitions, uses evidence

Figure: The Complete Health Leader — three integrated dimensions that together produce sustainable health impact

VI. PERSONAL LEADERSHIP PHILOSOPHY

A personal leadership philosophy is a clear, concise statement of your core beliefs about leadership — why it matters, what kind of leader you aspire to be, and what principles will guide your leadership behaviour. It is not a job description or a vision statement for an organization. It is a personal compass that guides your own development and decisions.

Leadership Philosophy Element	Guiding Question	Example
Core beliefs about leadership	What do I fundamentally believe about leadership? What is it for?	'I believe leadership is service — the leader's primary purpose is to create conditions where others can do their best work for the communities we serve.'
Values that guide my leadership	What values will I not compromise, regardless of pressure or context?	'Integrity, equity, evidence, and the dignity of every person — patient, community member, or staff — are non-negotiable in how I lead.'
Strengths I bring	What are my distinctive leadership contributions — what I do better than most?	'I am able to build trust across different stakeholder groups and translate complex technical evidence into accessible narratives that move people to action.'
Development edges	Where must I grow to realize my leadership potential?	'I need to develop greater comfort with public conflict — I tend to avoid difficult conversations and need to build the skill to address them constructively and early.'
The leader I aspire to be	In 10 years, what kind of leader do I want to have been?	'A leader who developed other leaders — whose most important legacy is not what I achieved but who I helped become.'

Case Study: Integration Case: Transformational Leadership in North Darfur

- Background: Dr. Amani has just been appointed State Director of Primary Health Care for North Darfur — one of the most challenging health leadership positions in Sudan. The state faces a GAM rate of 21%, maternal mortality among the highest in the country, only 34% of facilities with essential medicines available, and a health workforce depleted by years of conflict and out-migration. She has a mandate to transform primary health care outcomes within 3 years, a limited budget, an inherited management team of variable quality, and intense scrutiny from government, donors, and communities.
- Week 1 — Creating urgency (Kotter Step 1) + Evidence: Before making any announcements or decisions, Amani reads every health survey, Program evaluation, and facility assessment report from the past 3 years. She visits 6 health facilities personally in her first week — observing care, sitting with patients, talking to staff. In her first all-staff meeting, she shares the evidence: 'In this state, a child born in a rural community is 4 times more likely to die before age 5 than a child born in an urban area. That is not fate — it is a failure of systems that we are here to fix.'
- Month 1 — Vision + Coalition: She facilitates a 2-day participatory workshop with 45 stakeholders — district health officers, community leaders, women's representatives, NGO partners, the academic faculty. Together they develop a state vision and 5 strategic priorities. She forms a State Nutrition and PHC Coalition with government, UN agencies, and 8 NGOs — establishing joint protocols and a shared caseload register for the first time.
- Month 3 — Team building + HRM: She conducts structured performance conversations with all 12 district health officers — the first such conversations most have ever had. Three are identified for intensive coaching support; two who show leadership potential are given

expanded responsibilities. She introduces monthly district-level data review meetings with a standardized dashboard.

- Year 1 outcomes: Essential medicines availability increases from 34% to 61%. SAM treatment coverage increases from 29% to 54%. Skilled birth attendance increases from 41% to 56%. A Kordofan University research partnership produces the first independent facility quality assessment, used to target supervision resources.
- Discussion: Map Dr. Amani's actions across the three dimensions of the complete health leader (manages effectively, leads people, leads strategically). Which leadership theories from this course are most visible in her approach? What would you predict are the greatest risks to sustaining this transformation beyond her tenure? What personal leadership philosophy would be consistent with her behaviour?

Practical Activity: Personal Leadership Commitment — Final Assignment

- This assignment is your personal synthesis of the entire course. It is both analytical and reflective.
- Part 1 — Self-Assessment (500 words): Assess your own current leadership and management strengths and development edges using the frameworks from this course. Consider: Which management functions (Sessions 4-9) do you feel most and least confident in? Which leadership type (Strategic, Visionary, Transformational) resonates most with your current role and aspiration? What cognitive biases (Session 2) are you most susceptible to? What is your dominant conflict style (Session 7) — and when is it helpful vs. limiting?
- Part 2 — Personal Leadership Philosophy (300 words): Write your personal leadership philosophy using the five elements from this session: core beliefs about leadership; values that guide your leadership; strengths you bring; development edges; the leader you aspire to be.
- Part 3 — Development Plan (300 words): Identify three specific competency areas you will develop over the next 12 months. For each: name the competency; explain why it is a priority for you; describe specifically how you will develop it (what will you read, practise, or seek feedback on?); identify how you will know you have improved.
- Part 4 — Course Reflection (200 words): Which single concept, framework, or idea from this course has most changed how you think about leadership and management? How will you apply it in your current or future role?

Reflection / Discussion Questions

- Evidence-based decision making requires intellectual humility — the willingness to change your mind when evidence challenges your prior beliefs. Think of a decision you have made or observed where evidence was available but not used. What drove the non-evidence-based choice? What would have been required to change it?
- This course has covered a large body of management and leadership theory — much of it developed in Western organizational contexts. Which theories do you find most directly applicable to health Program leadership in Sudan? Which require significant adaptation? And are there important aspects of effective leadership in Sudan's health system that are not captured by any of the theories in this course?
- The course ends with a commitment to continued personal development. But sustained self-development requires honest self-knowledge — which is difficult without regular feedback and reflection. What specific practices will you put in place to ensure you continue to grow as a leader after this course ends?

Session Summary — Key Takeaways

- The transformational leader grounds vision in evidence: the complete health leader uses the best available evidence to make decisions, tracks whether their decisions achieved the intended outcomes, and learns systematically from both successes and failures. Evidence-based decision making integrates research evidence + Program data + professional expertise + stakeholder values.
- The hierarchy of evidence (from systematic reviews at Level 1 to expert opinion at Level 6) guides reliability assessment — not a prescription for paralysis. Use the best available evidence at each level, acknowledge its limitations, and always prefer structured evidence over unstructured intuition. The six barriers to evidence use (availability, accessibility, understanding, trust, authority conflicts, time) each have specific leadership responses.
- The transformational leader creates a learning organization by: modelling personal learning (admitting mistakes openly); creating space for team learning (AARs, reflection rituals); using data for learning (not just reporting); and building systems for learning (knowledge management, peer learning, research partnerships). The After-Action Review is the core learning practice: What did we intend? What happened? Why the difference? What do we change?
- The complete health leader integrates three dimensions: Manages effectively (delivering results through systems, processes, and accountability); Leads people (inspiring, developing, building teams, managing conflict); Leads strategically (shaping the environment, building coalitions, communicating vision, using evidence). No single dimension is sufficient — all three must develop together.
- A personal leadership philosophy is a compass for continued development: core beliefs about leadership; values that guide behaviour; distinctive strengths; development edges; the leader you aspire to be. It is revisited regularly — not fixed — and grows with experience, reflection, and honest feedback from those you lead and serve.
- Course synthesis: This course has given you the conceptual vocabulary, analytical frameworks, and practical tools to manage health Programs effectively and lead people and organizations toward health impact. The most important thing you can do with this learning is use it — apply it honestly to your context, adapt it where needed, and commit to continued growth as a leader who makes a difference to the health of the people you serve.

Course Synthesis — Integrating the Learning Journey

- Topic 1 (Sessions 1-3): Management concepts, POLC, decision-making, manager vs. leader, leadership styles, situational leadership
- Topic 2 (Sessions 4-9): Program design & LogFrame, strategic planning & SWOT/Balanced Scorecard, time management & Eisenhower Matrix, HRM & conflict resolution, team building & Tuckman/Belbin/Lencioni, monitoring & evaluation & data use
- Topic 3 (Sessions 11-14): Leadership theory evolution (trait through complexity), strategic leadership & coalitions & power & networks, visionary leadership & vision/mission/OKRs/Kotter, transformational leadership & evidence-based decision making & learning organization
- Connecting thread across all sessions: The MSH Managers Who Lead framework — managing (plan, organize, implement, monitor) and leading (scan, focus, align, inspire) are complementary, not competing. The health Program manager who masters both is the health leader Sudan's communities need.

Suggested Reading:

1. Sackett DL et al. (1996). Evidence-based medicine: What it is and what it isn't. BMJ. |
2. Senge PM (1990). The Fifth Discipline: The Art and Practice of the Learning Organization. |
3. Pfeffer J & Sutton RI (2006). Hard Facts, Dangerous Half-Truths & Total Nonsense: Profiting from Evidence-Based Management. |
4. MSH (2008). Managers Who Lead — Final Chapter: Sustaining Your Leadership. | WHO (2020). Everybody's Business: Strengthening Health Systems to Improve Health Outcomes.

Management and Leadership of Health Programs

PHLM 516 | Lecture Series Reader |

School of Health Sciences | Ahfad University for Women | 2026

ABOUT THIS READER

This course reader is specifically designed for students in the BSc Public Health program to navigate the complexities of managing and leading health initiatives. It provides a comprehensive academic foundation by bridging the gap between theoretical management frameworks and the practical realities of health program implementation. By exploring the core functions of management—planning, organizing, leading, and controlling—alongside advanced leadership theories, the material equips future public health professionals with the tools necessary to make evidence-based decisions, manage diverse teams, and optimize resource allocation in challenging environments.

The content is structured to foster both technical proficiency and strategic thinking, moving from fundamental concepts to specialized topics such as human resource management, strategic planning, and monitoring and evaluation. A central theme throughout the reader is the integration of the "Managers Who Lead" framework, which emphasizes that effective health leaders must simultaneously manage operational systems and inspire collective action. Through this integrated approach, the reader serves as a vital resource for developing the leadership competencies required to strengthen health systems and improve community health outcomes during periods of both stability and crisis.

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Professor Salih *holds academic expertise in nutrition science, public health policy, and program design. He has led curriculum development, research initiatives, and nutrition policy advisory work across Sudan's health and education sectors for over two decades.*

He founded and leads the Nutrition Center for Training & Research (NHCTR), Sudan's only Nutrition Research Center composed exclusively of nutrition and public health specialists, established in January 2010 at AUW

He founded and leads the Together for Sustainable Nutrition (TSN), Sudan's only civil society organization composed exclusively of nutrition and public health specialists, established in December 2025 with a membership spanning clinical nutrition, emergency nutrition, food security, and food sciences.

His work bridges academic scholarship, policy advocacy, and humanitarian programming — with a sustained focus on Sudan's most vulnerable populations: women, children, and conflict-affected communities.

School of Health Sciences

Ahfad University for Women (AUW)

Omdurman, Sudan

NUDT 414 | 2 Credit Hours

Food & Nutrition Policy & Planning

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